Child and Adult Care Food Program

Website Tour

www.bestbeginnings.mt.gov

Online Applications and Claims

DPHHS-OM-300B
(Rev. 08/2012)

STATE OF MONTANA
Department of Public Health and Human Services

FAX completed form, within three (3) working days, to TSD/NCB Network Security Unit at (406) 444-5924
If fax not available, please mail to: 111 N Sanders, Rm 204, Helena MT 59620 (Original form not required if faxed)

NON-DPHHS EMPLOYEE SYSTEM/FILE ACCESS REQUEST

LEGAL Name of Individual Requiring Access: _____
(Please Print) *First* *MI* *Last*

Logon ID: _____ **Create Logon ID:** ☐

Start Date: _____

Employed with DPHHS before: ☐

DPHHS Positions Only:
Need Computer: ☐
Accessories: Dual Video: ☐
Ergonomic Keyboard: ☐

Transferring from another DPHHS Division: ☐

Other Name(s) Used *(Maiden or previous married name)* _____

Employer: _____ **Work Phone:** _____

Work Address: _____ **County:** _____

_____ **Job Title:** _____

E-mail Address: _____

Please list access requested here:

Justification *(Give a brief description as to why access is needed):*

CONFIDENTIALITY/CONSENT STATEMENT: (To be read and signed by the individual requiring access.)

Online Applications

http://ows.hhs.mt.gov/pls/cacfpcom/gs_logon_psp_pkg.home - Windows Internet Explorer

http://ows.hhs.mt.gov/pls/cacfpcom/gs_logon_psp_pkg.home

File Edit View Favorites Tools Help

Favorites http://ows.hhs.mt.gov/pls/cacfpcom/gs_logon_...

Page Safety Tools

Montana CACFP

photo by Travel Montana

Institution Detail

Change Password

Help
Home
Logout

Welcome

[redacted]

Done

Local intranet | Protected Mode: Off

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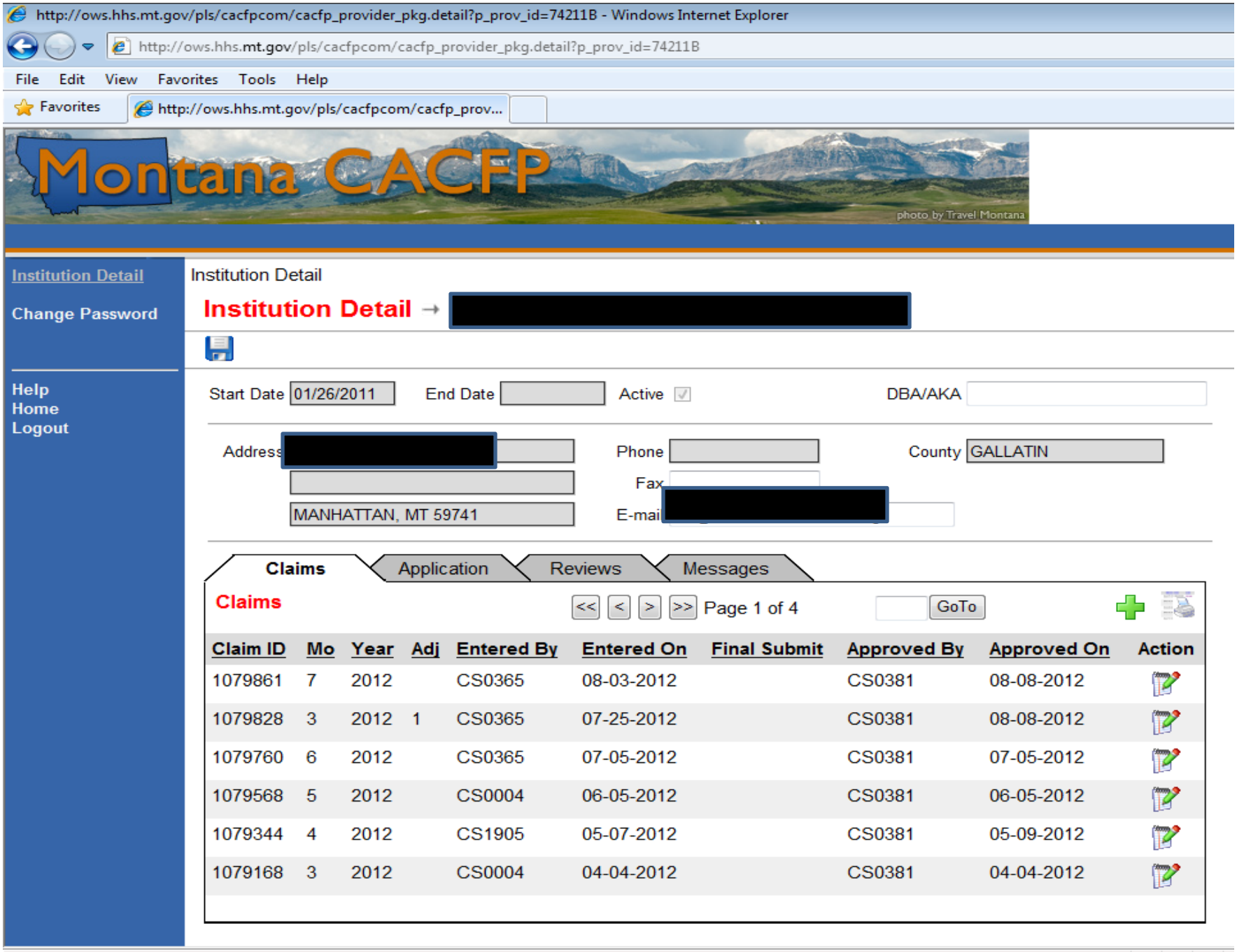
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Institution Detail →
[redacted]
Start Date 01/26/2011
End Date
Active
DBA/AKA
Address [redacted]
MANHATTAN, MT 59741
Phone
Fax
E-mai [redacted]
County GALLATIN
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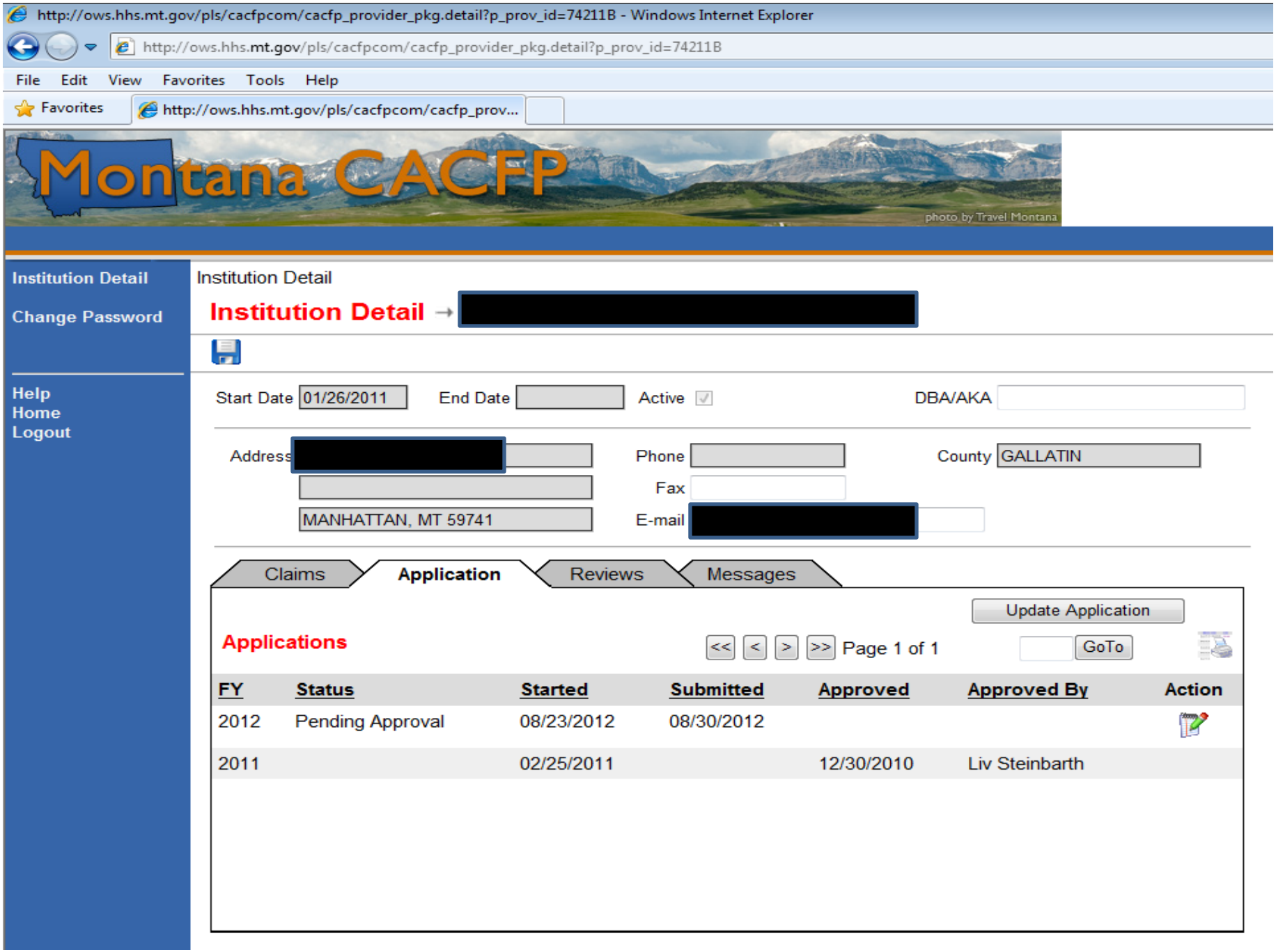
Claim ID Mo Year Adj Entered By Entered On Final Submit Approved By Approved On Action
1079861 7 2012 CS0365 08-03-2012 CS0381 08-08-2012
1079828 3 2012 1 CS0365 07-25-2012 CS0381 08-08-2012
1079760 6 2012 CS0365 07-05-2012 CS0381 07-05-2012
1079568 5 2012 CS0004 06-05-2012 CS0381 06-05-2012
1079344 4 2012 CS1905 05-07-2012 CS0381 05-09-2012
1079168 3 2012 CS0004 04-04-2012 CS0381 04-04-2012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Home
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Institution Detail
Institution Detail → [redacted]
Start Date 01/26/2011
End Date
Active
DBA/AKA
Address [redacted]
MANHATTAN, MT 59741
Phone
Fax
E-mail [redacted]
County GALLATIN
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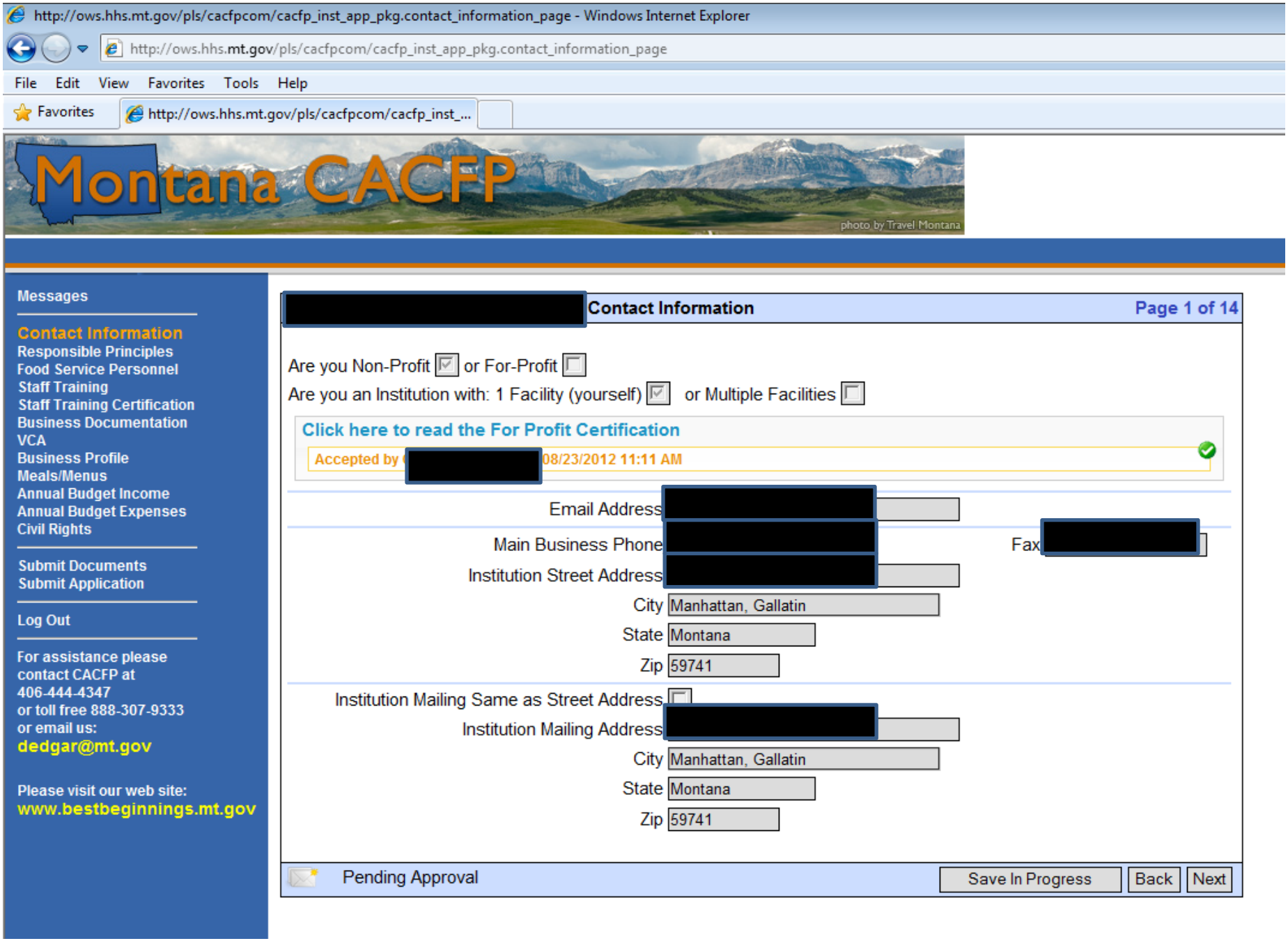
FY Status Started Submitted Approved Approved By Action
2012 Pending Approval 08/23/2012 08/30/2012
2011 02/25/2011 12/30/2010 Liv Steinbarth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dedgar@mt.gov
Please visit our web site:
www.bestbeginnings.mt.gov
[redacted] Contact Information
Page 1 of 14
Are you Non-Profit or For-Profit
Are you an Institution with: 1 Facility (yourself) or Multiple Facilities
Click here to read the For Profit Certification
Accepted by [redacted] 08/23/2012 11:11 AM
Email Address [redacted]
Main Business Phone [redacted]
Fax [redacted]
Institution Street Address [redacted]
City Manhattan, Gallatin
State Montana
Zip 59741
Institution Mailing Same as Street Address
Institution Mailing Address [redacted]
City Manhattan, Gallatin
State Montana
Zip 59741
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[redacted] **Responsible Principles** Page 2 of 14

Institution Director	First	Sarah	Last	Sosa	Date of Birth	05/19/1974
Individual Signing Contract Same as Director	☐					
Individual Signing Contract	First	Sammy	Last	Sosa	Date of Birth	05/19/1974
Director Address Same as Institution Address	☐					
Director Address	[redacted]					
City	Manhattan, Gallatin					
State	Montana		Zip	59741		
Owner Same as Director	☐					
Owner Name	First	Sammy	Last	Sosa	Date of Birth	05/19/1974
Owner Address	[redacted]					
City	Manhattan, Gallatin					
State	Montana		Zip	59741		
Board President / Chair	First	Mister	Last	President	Date of Birth	02/15/1952
President / Chair Address	111 SYZ Street					
City	Manhattan, Gallatin					
State	Montana		Zip	59741		

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[redacted] **Food Service Personnel** Page 3 of 14

First Name	Last Name	Title	Phone	
C	Cook		(406)444-3569	
Davey	Jones		(406)444-3569	

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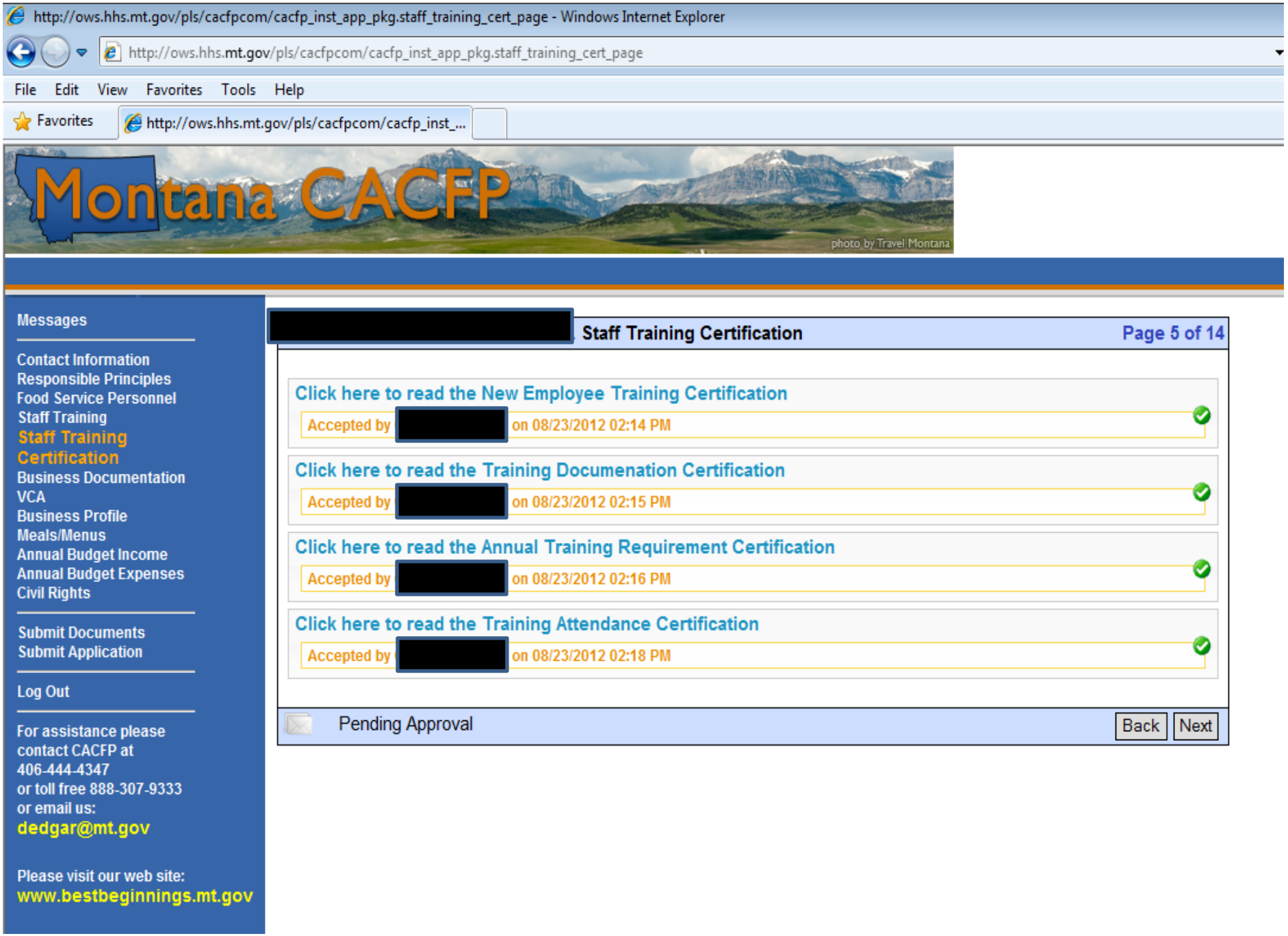
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[redacted]
Staff Training Certification
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Click here to read the New Employee Training Certification
Accepted by [redacted] on 08/23/2012 02:14 PM
Click here to read the Training Documenation Certification
Accepted by [redacted] on 08/23/2012 02:15 PM
Click here to read the Annual Training Requirement Certification
Accepted by [redacted] on 08/23/2012 02:16 PM
Click here to read the Training Attendance Certification
Accepted by [redacted] on 08/23/2012 02:18 PM
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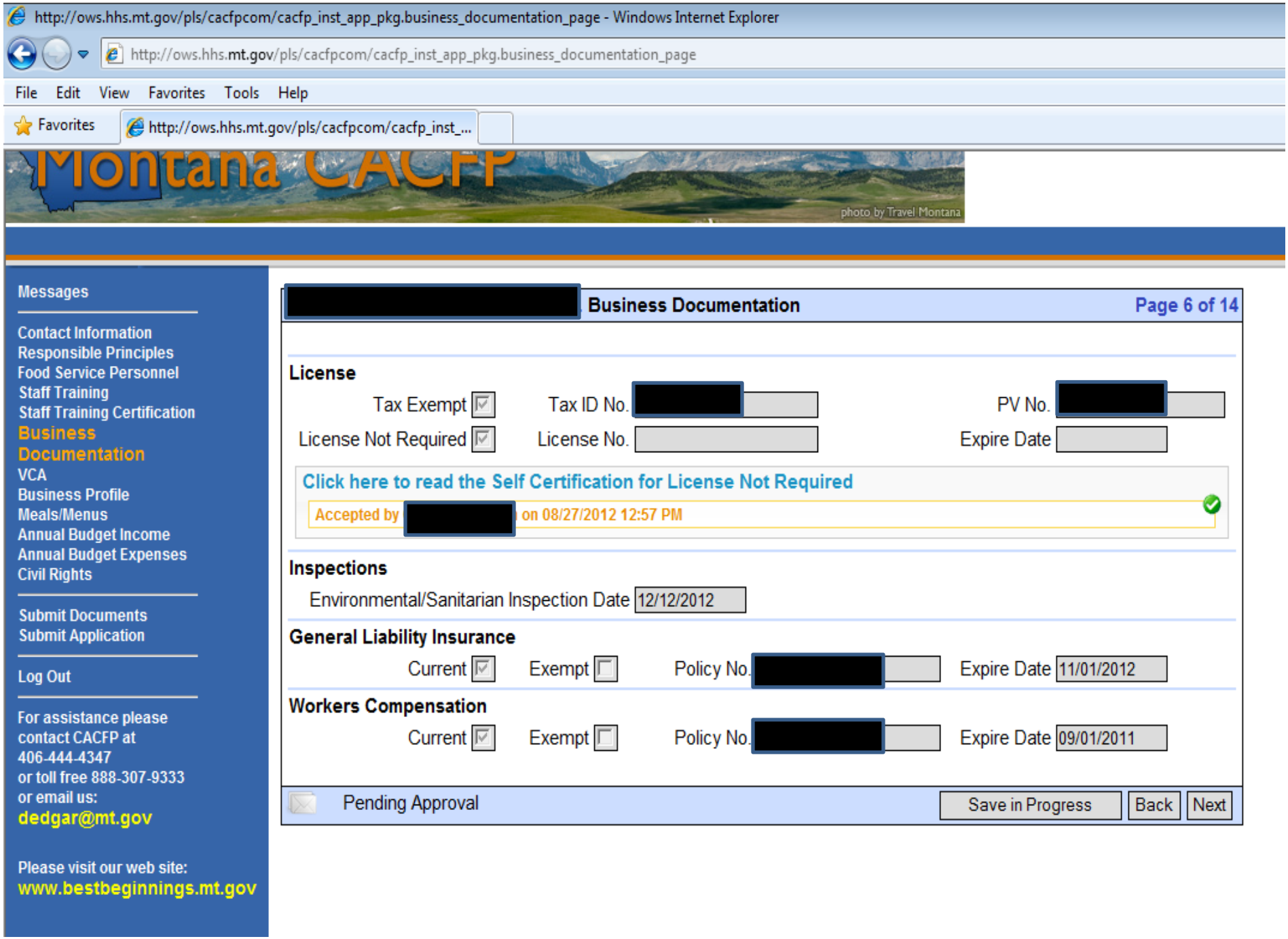
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[redacted] Business Documentation Page 6 of 14
License
Tax Exempt
Tax ID No. [redacted]
PV No. [redacted]
License Not Required
License No.
Expire Date
Click here to read the Self Certification for License Not Required
Accepted by [redacted] on 08/27/2012 12:57 PM
Inspections
Environmental/Sanitarian Inspection Date 12/12/2012
General Liability Insurance
Current
Exempt
Policy No. [redacted]
Expire Date 11/01/2012
Workers Compensation
Current
Exempt
Policy No. [redacted]
Expire Date 09/01/2011
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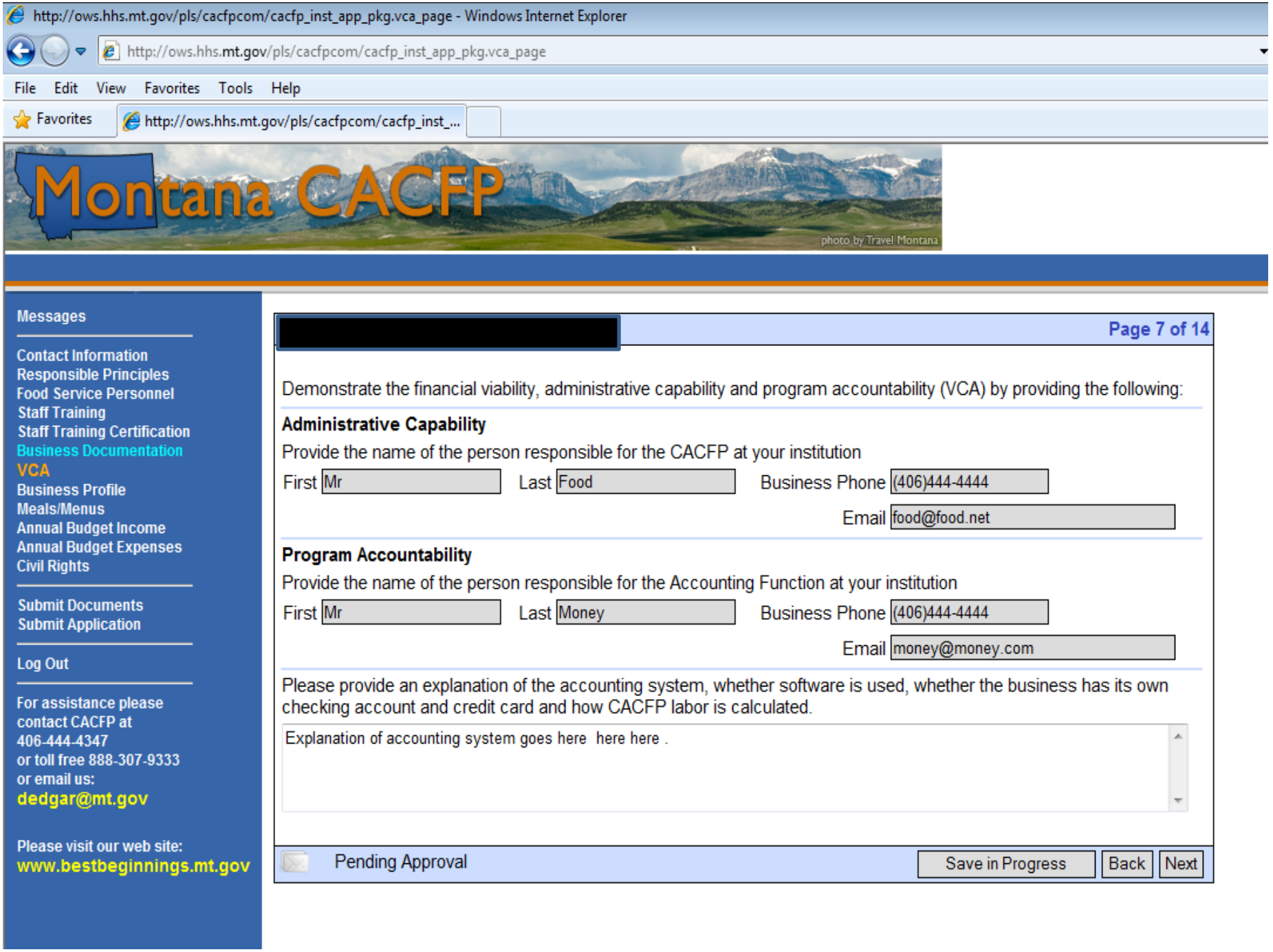
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Please visit our web site: www.bestbeginnings.mt.gov
[redacted]
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Demonstrate the financial viability, administrative capability and program accountability (VCA) by providing the following:
Administrative Capability
Provide the name of the person responsible for the CACFP at your institution
First Mr
Last Food
Business Phone (406)444-4444
Email food@food.net
Program Accountability
Provide the name of the person responsible for the Accounting Function at your institution
First Mr
Last Money
Business Phone (406)444-4444
Email money@money.com
Please provide an explanation of the accounting system, whether software is used, whether the business has its own checking account and credit card and how CACFP labor is calculated.
Explanation of accounting system goes here here here .
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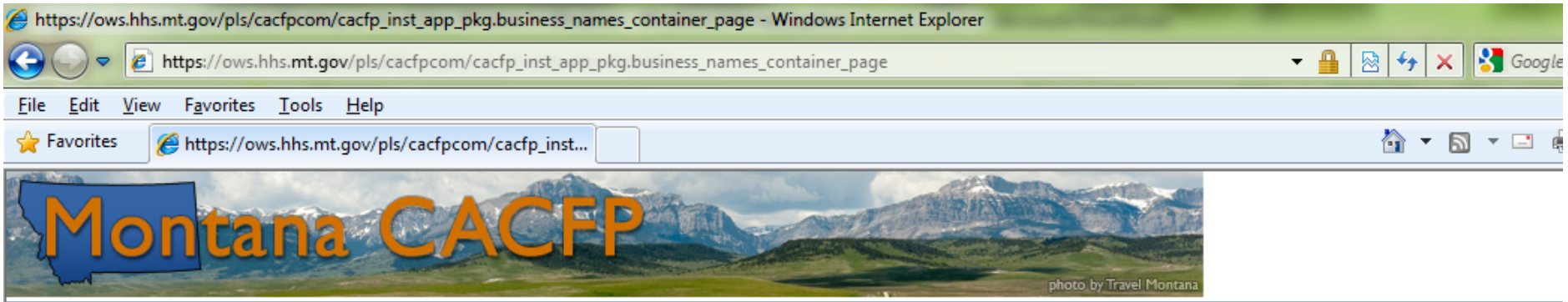

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[redacted] **Business Profile** Page 8 of 14

Center Type: Day Care

I agree to accept cash in lieu of commodities: ☑

The age range of children in care is 0 to 10

The Licensed or Authorized Capacity is 36

Hours of operation are from 06:00 AM to 05:00 PM

Days of operation are:

Sunday ☐ Monday ☑ Tuesday ☑ Wednesday ☑ Thursday ☑ Friday ☑ Saturday ☐

List all dates which the institution will not operate for periods of 1 week or longer (including spring or summer break).

☐ Not Applicable

June 13-August 2

Add Other Business Names if Applicable

Other Business Name	Type of Business	Start	End	
[redacted]	Day Care	08/29/2012	09/28/2012	

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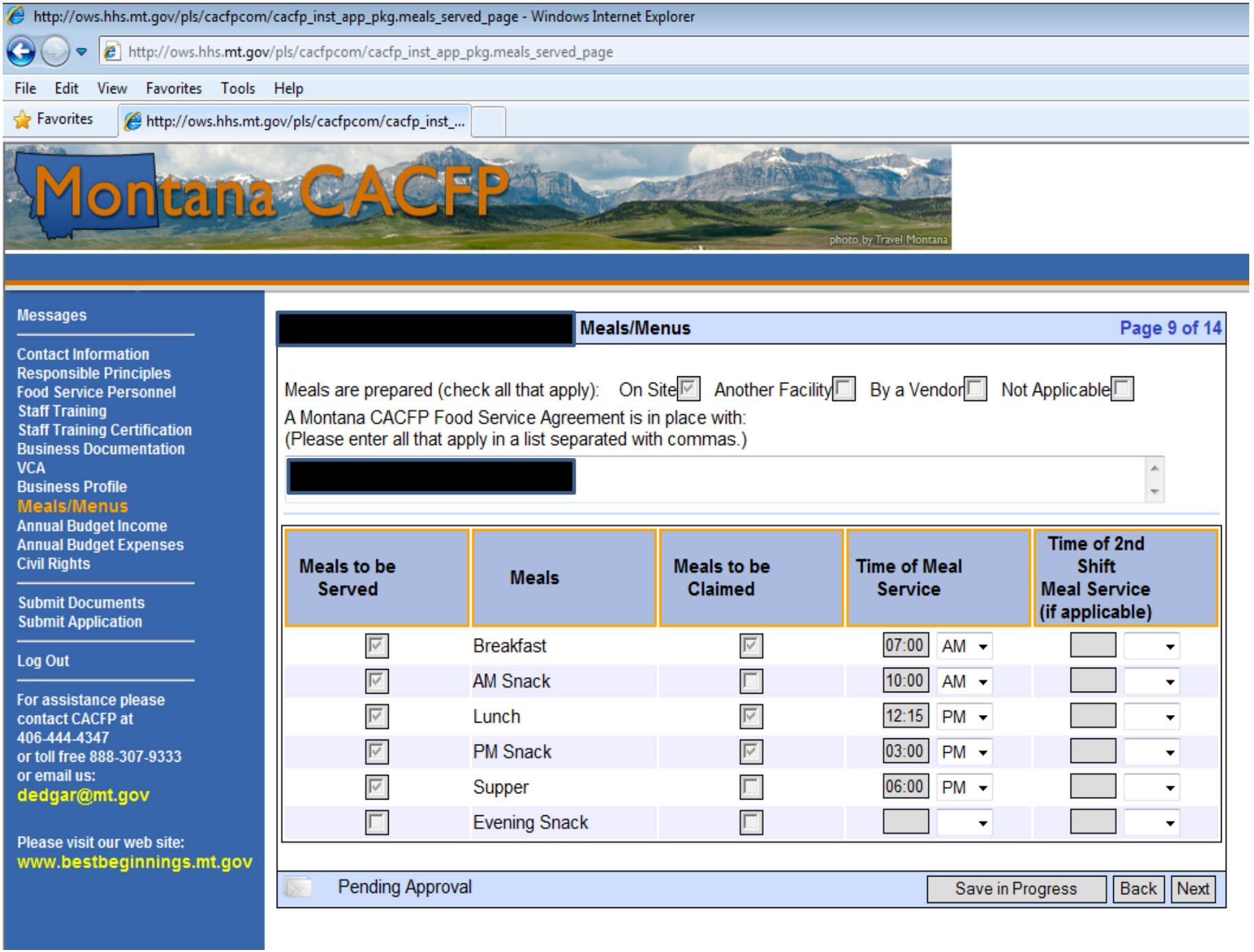
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[redacted]
Meals/Menus
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Meals are prepared (check all that apply): On Site Another Facility By a Vendor Not Applicable
A Montana CACFP Food Service Agreement is in place with:
(Please enter all that apply in a list separated with commas.)
[redacted]
Meals to be Served
Meals
Meals to be Claimed
Time of Meal Service
Time of 2nd Shift Meal Service (if applicable)
Breakfast 07:00 AM
AM Snack 10:00 AM
Lunch 12:15 PM
PM Snack 03:00 PM
Supper 06:00 PM
Evening Snack
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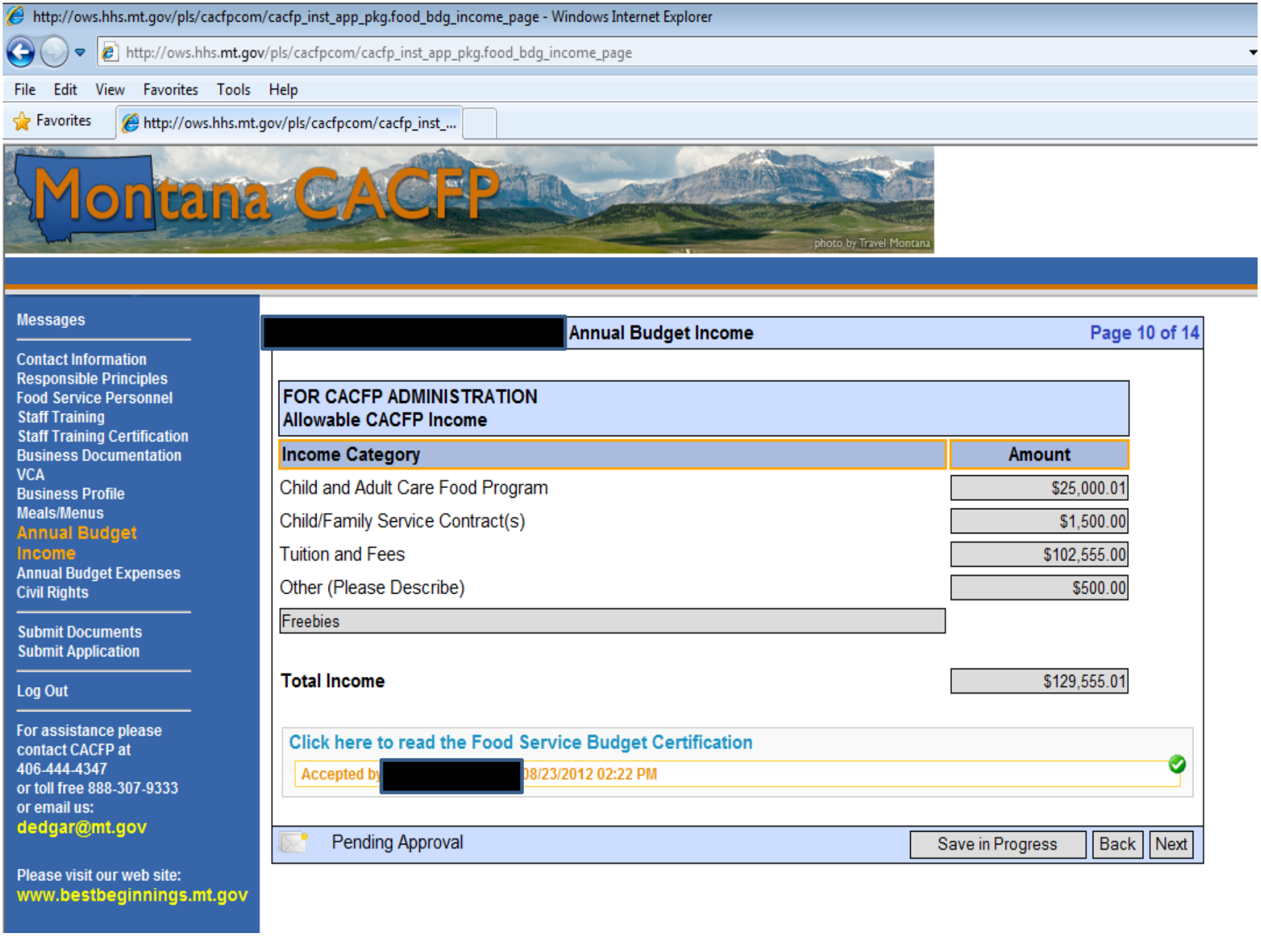
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www.bestbeginnings.mt.gov
[redacted]
Annual Budget Income
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FOR CACFP ADMINISTRATION
Allowable CACFP Income
Income Category
Amount
Child and Adult Care Food Program
$25,000.01
Child/Family Service Contract(s)
$1,500.00
Tuition and Fees
$102,555.00
Other (Please Describe)
$500.00
Freebies
Total Income
$129,555.01
Click here to read the Food Service Budget Certification
Accepted by [redacted] 08/23/2012 02:22 PM
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[redacted] **Annual Budget Expenses**

Expenditure Category	Amount
FOR CACFP ADMINISTRATION Allowable CACFP Expenses	
Food	$15,000.00
Milk	$4,000.00
Food Service Labor (cook's salary, etc.)	$2,001.00
Cleaning Supplies (dishwashing soap, etc.)	$52,001.00
Nonfood Supplies (paper napkins, etc.)	$22.00
Food Service Equipment	$170,001.00
Staff Training Costs for the CACFP	$5,202.00
Administrative Costs for the CACFP	$1,001.00
General Liability Insurance and Workers Compensation Insurance	$2,001.00
Overhead (Rent, Utilities)	$150,001.01
Total Expenses	$401,230.01

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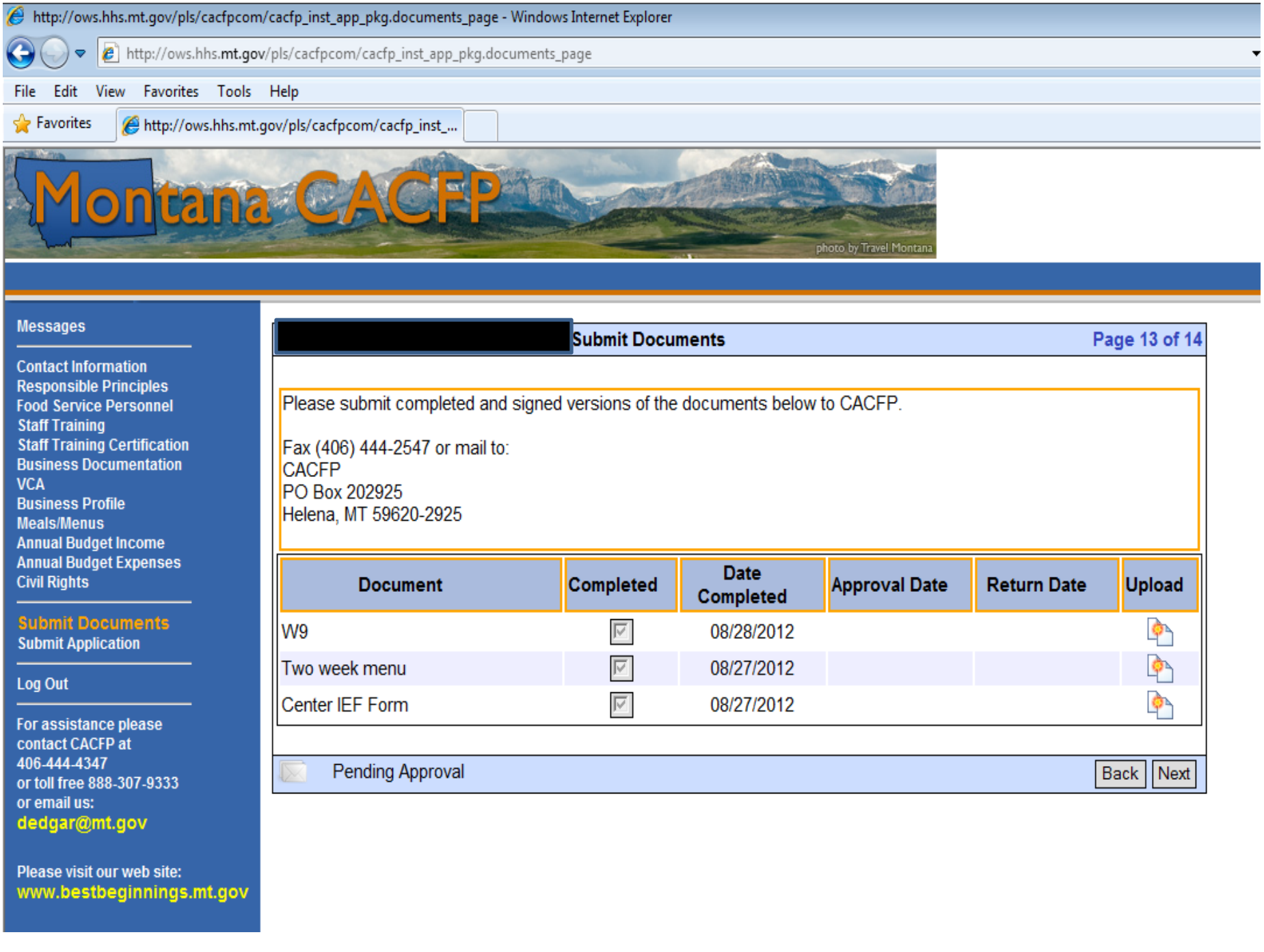
[redacted] **Civil Rights**

Detailed Enrollment by County

County	Total	Edit/Delete
Beaverhead	0	
Big Horn	22	
Blackfeet Reservation	0	
Broadwater	4	
Carbon	1	
Carter	1	
Cascade	10	
Chouteau	0	
Custer	0	
Fergus	17	
Flathead	1	
Judith Basin	0	
Lewis and Clark	10875	
Missoula	1	
Total	10932	

Total Census Data

Ethnicity	Census	Actual
White	378452	5842
Black	2039	218
Native American	18915	1523
Asian	3019	26
Native Hawaiian/Pacific Isl.	369	42
Other	2076	300
Two or More Races	10413	1400
Hispanic	10936	1581
Total	426219	10932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Please submit completed and signed versions of the documents below to CACFP.
Fax (406) 444-2547 or mail to:
CACFP
PO Box 202925
Helena, MT 59620-2925
Document
Completed
Date Completed
Approval Date
Return Date
Upload
W9
08/28/2012
Two week menu
08/27/2012
Center IEF Form
08/27/2012
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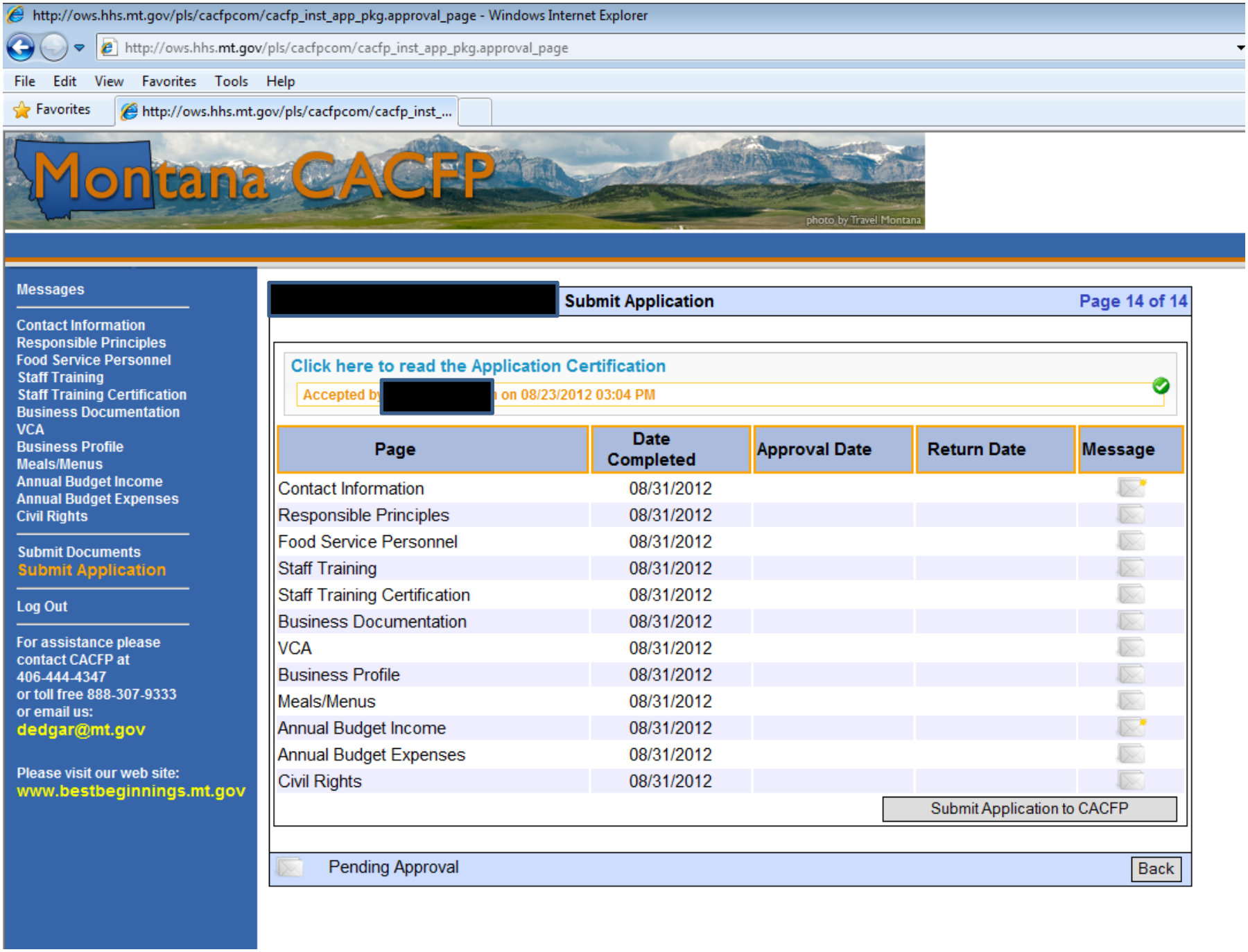
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[redacted]
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Click here to read the Application Certification
Accepted by [redacted] on 08/23/2012 03:04 PM
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Date Completed
Approval Date
Return Date
Message
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Annual Budget Income 08/31/2012
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Page Safety Tools

Institution Detail

Change Password

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Home
Logout

Welcome

[redacted]

Done

Local intranet | Protected Mode: Off

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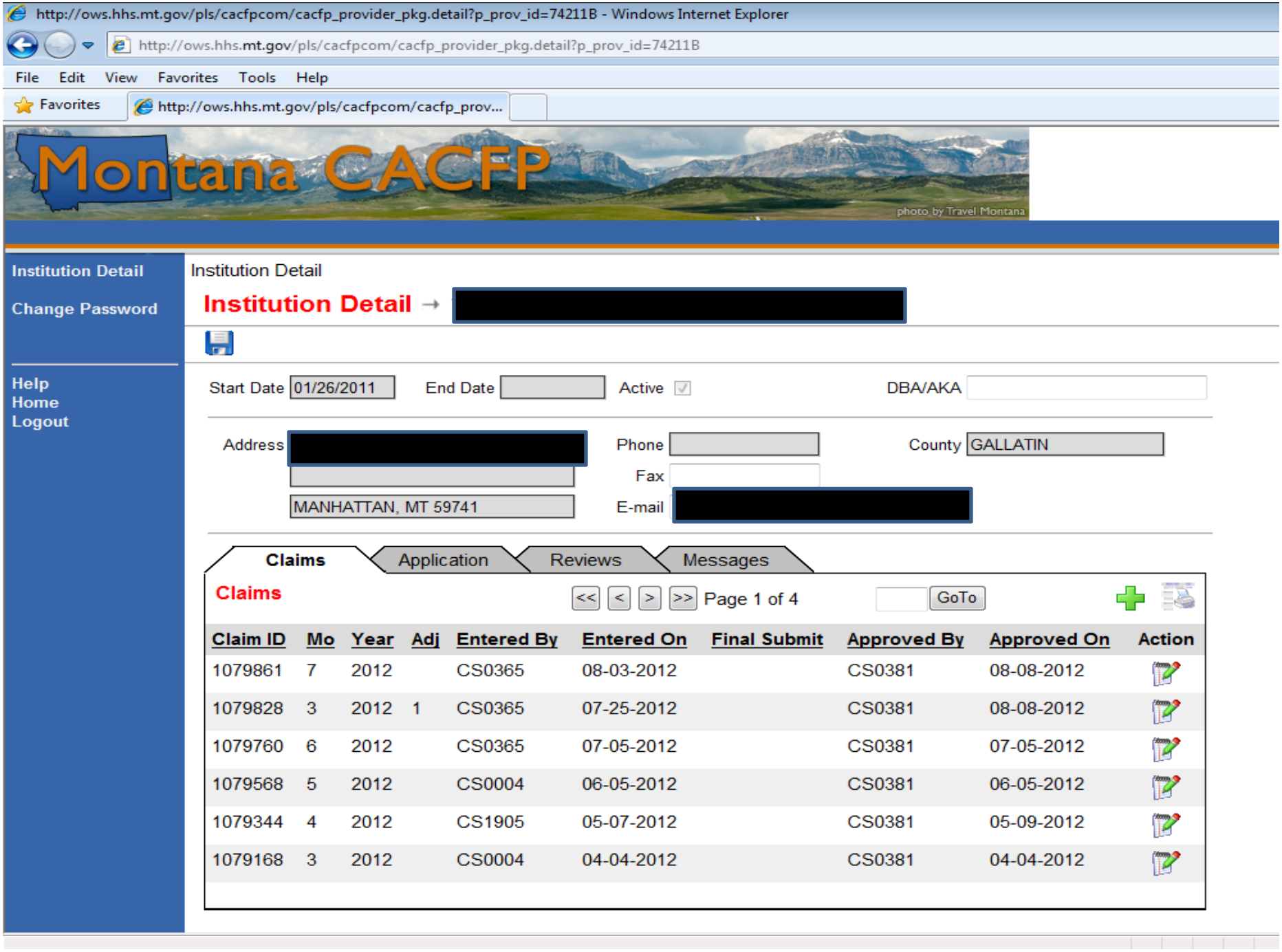
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<< < > >> Page 1 of 4
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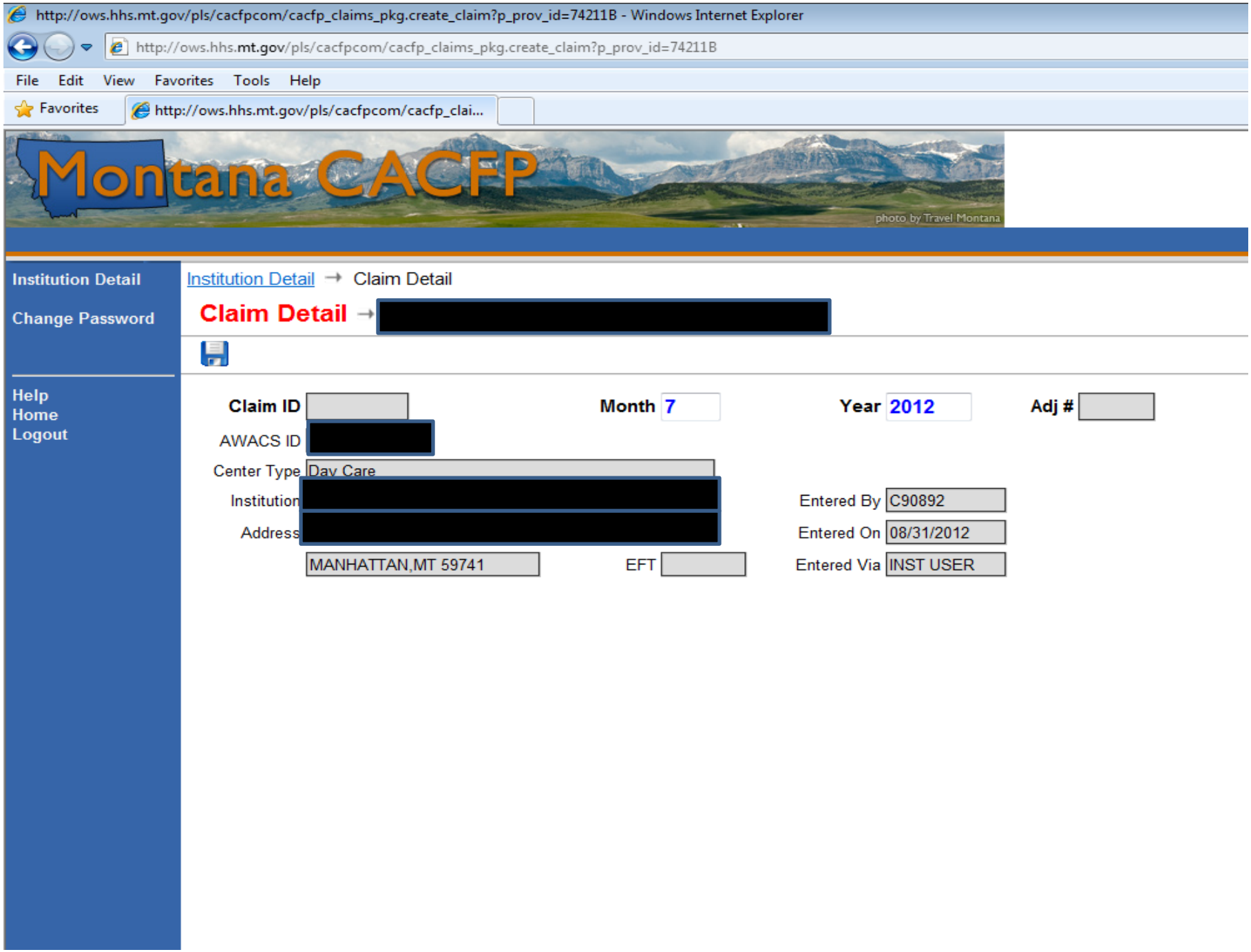
1079828 | 3 | 2012 | 1 | CS0365 | 07-25-2012 | | CS0381 | 08-08-2012
1079760 | 6 | 2012 | | CS0365 | 07-05-2012 | | CS0381 | 07-05-2012
1079568 | 5 | 2012 | | CS0004 | 06-05-2012 | | CS0381 | 06-05-2012
1079344 | 4 | 2012 | | CS1905 | 05-07-2012 | | CS0381 | 05-09-2012
1079168 | 3 | 2012 | | CS0004 | 04-04-2012 | | CS0381 | 04-04-2012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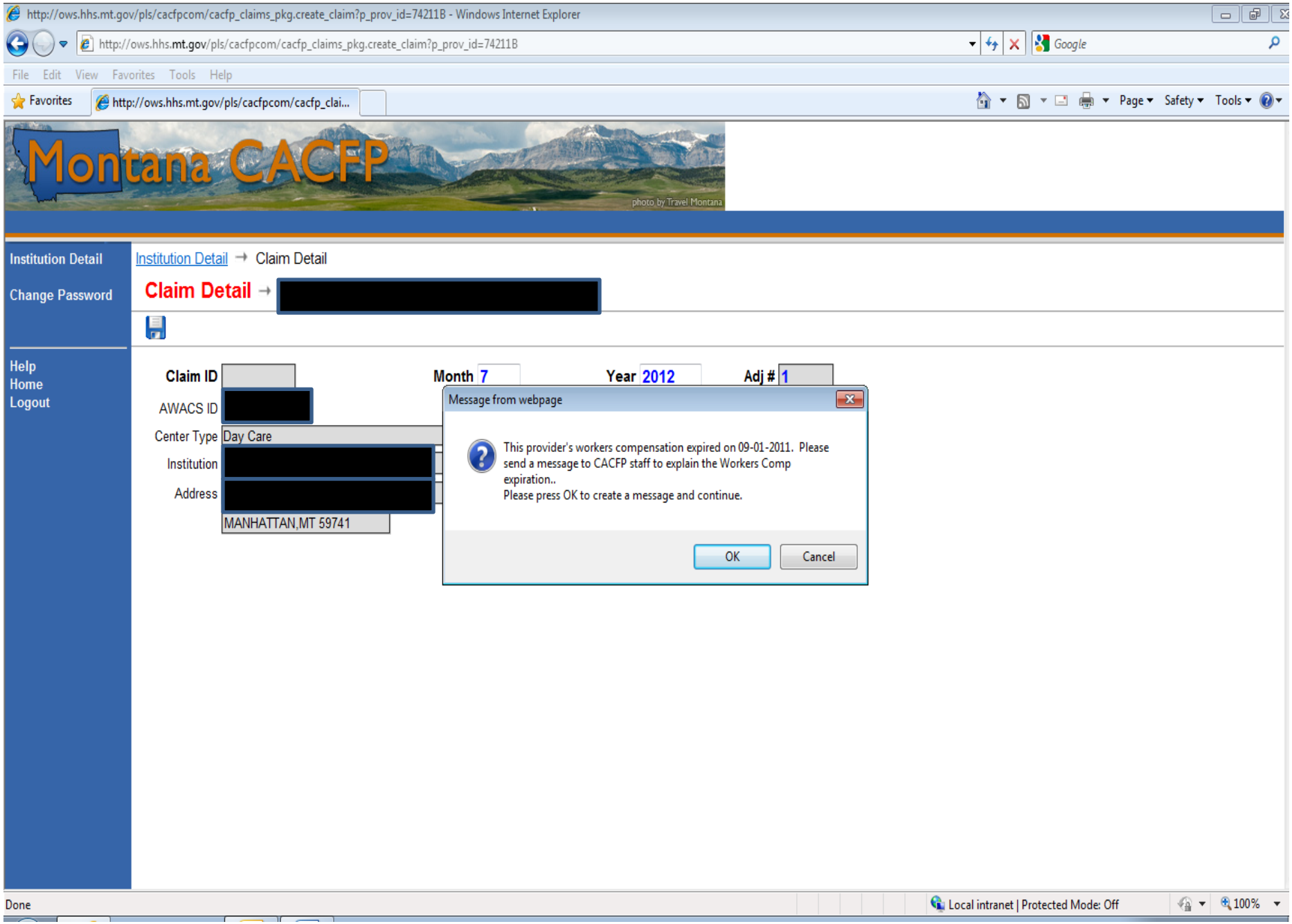
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MANHATTAN,MT 59741
Message from webpage
This provider's workers compensation expired on 09-01-2011. Please send a message to CACFP staff to explain the Workers Comp expiration..
Please press OK to create a message and continue.
OK
Cancel
Done
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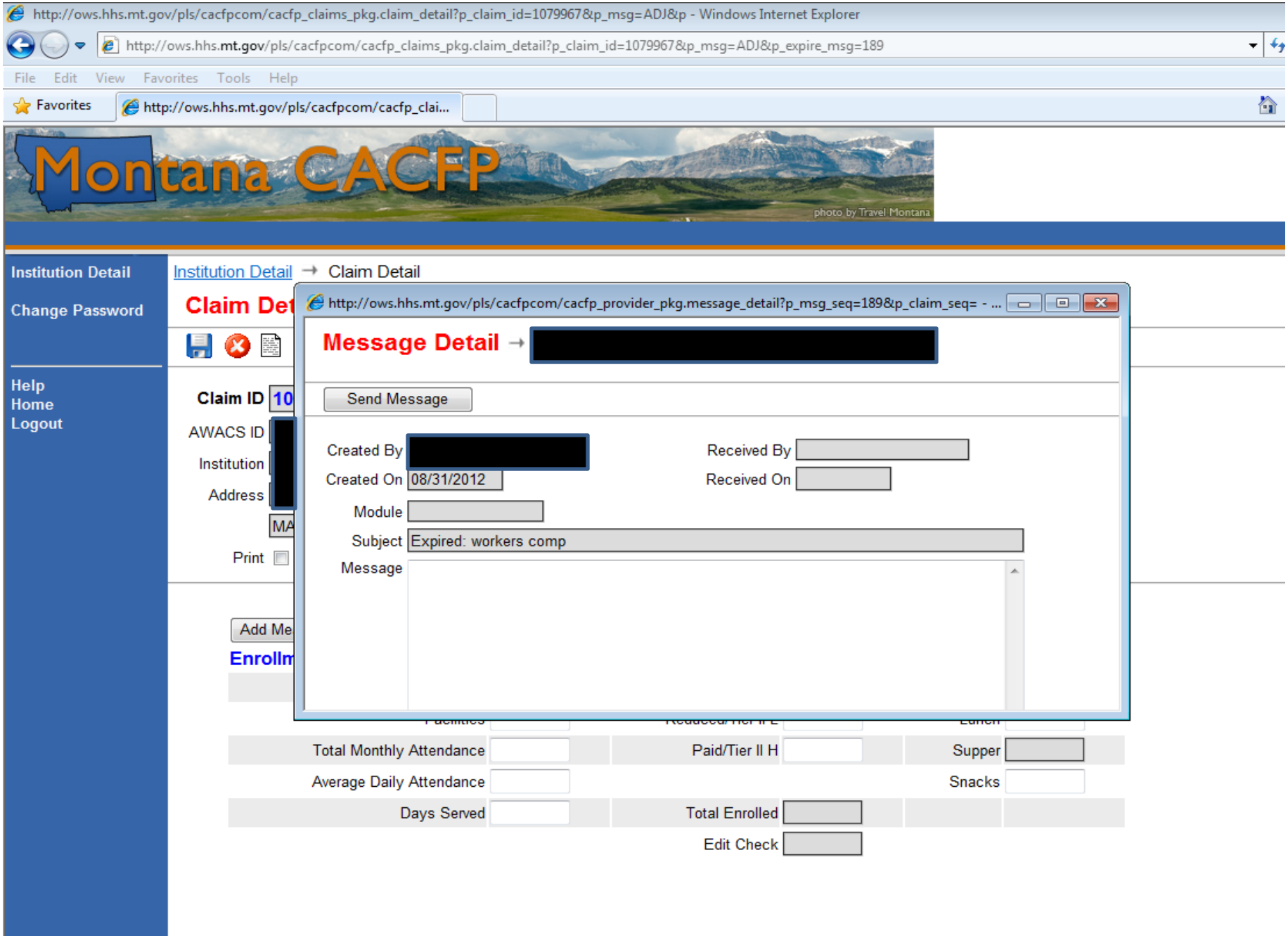
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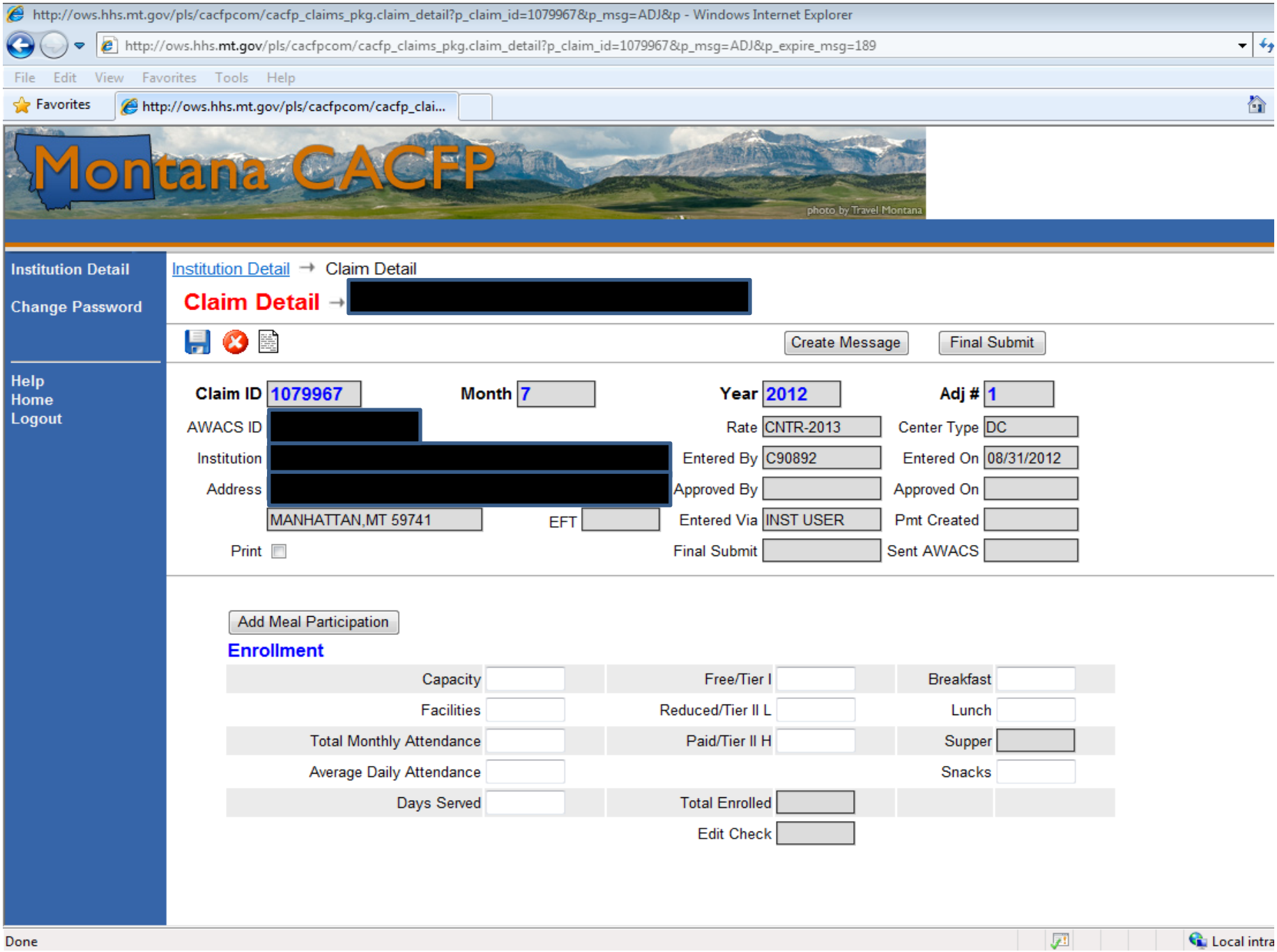
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Center Type DC
Institution [redacted]
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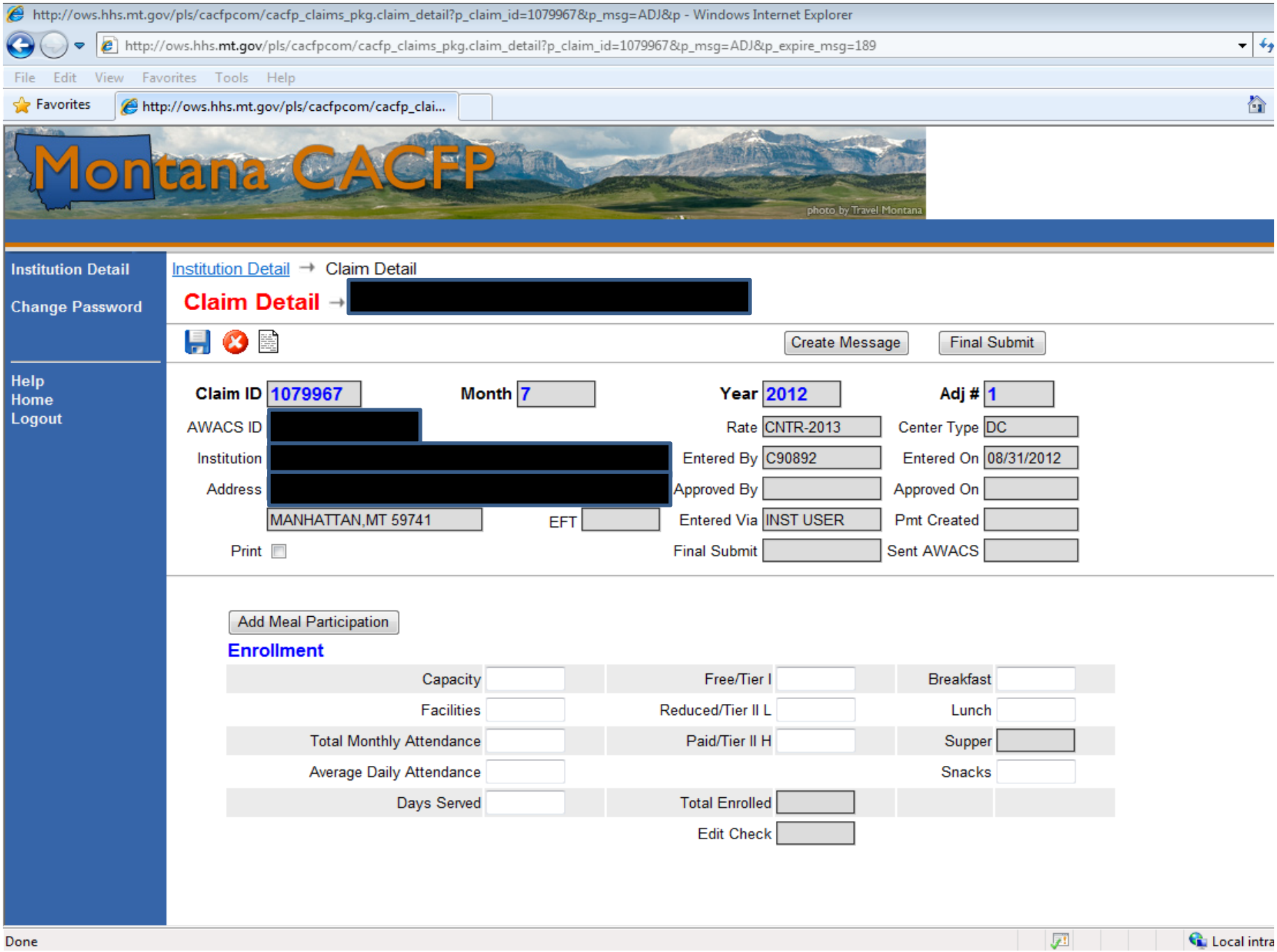
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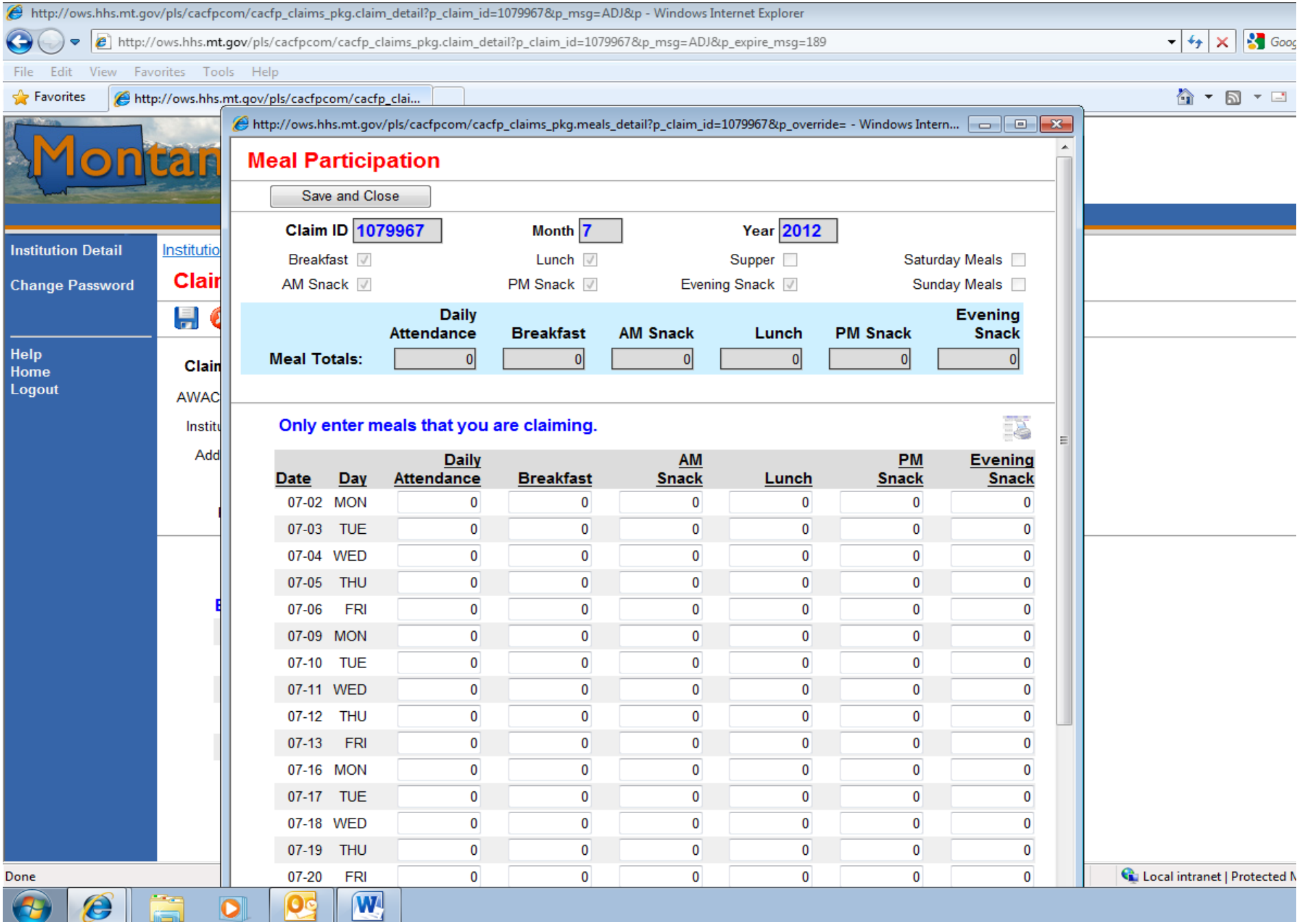
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AM Snack
PM Snack
Evening Snack
Sunday Meals
Daily Attendance
Breakfast
AM Snack
Lunch
PM Snack
Evening Snack
Meal Totals: 0 0 0 0 0 0
Only enter meals that you are claiming.
Date Day Daily Attendance Breakfast AM Snack Lunch PM Snack Evening Snack
07-02 MON 0 0 0 0 0 0
07-03 TUE 0 0 0 0 0 0
07-04 WED 0 0 0 0 0 0
07-05 THU 0 0 0 0 0 0
07-06 FRI 0 0 0 0 0 0
07-09 MON 0 0 0 0 0 0
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07-11 WED 0 0 0 0 0 0
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07-13 FRI 0 0 0 0 0 0
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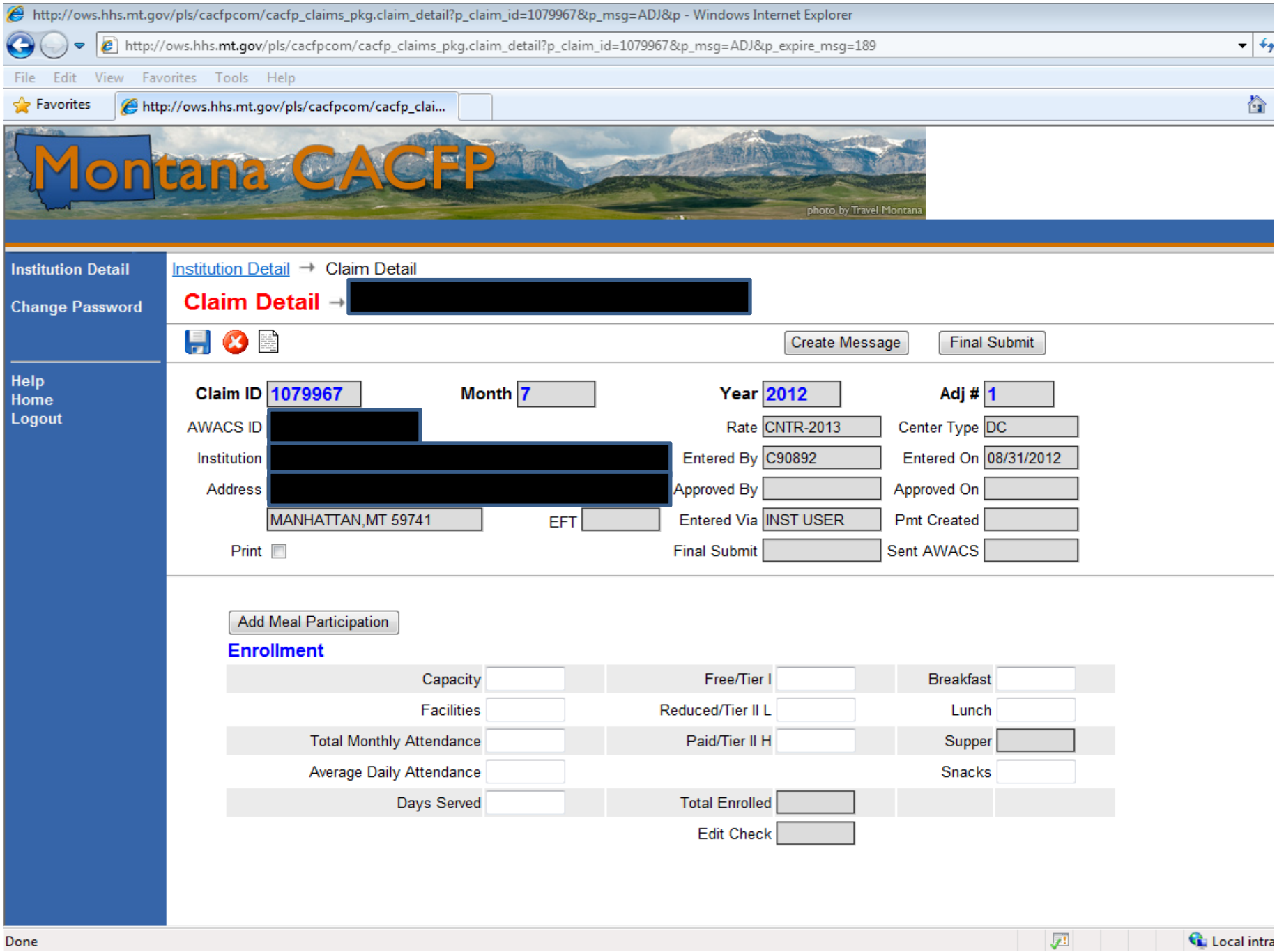
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Institution [redacted]
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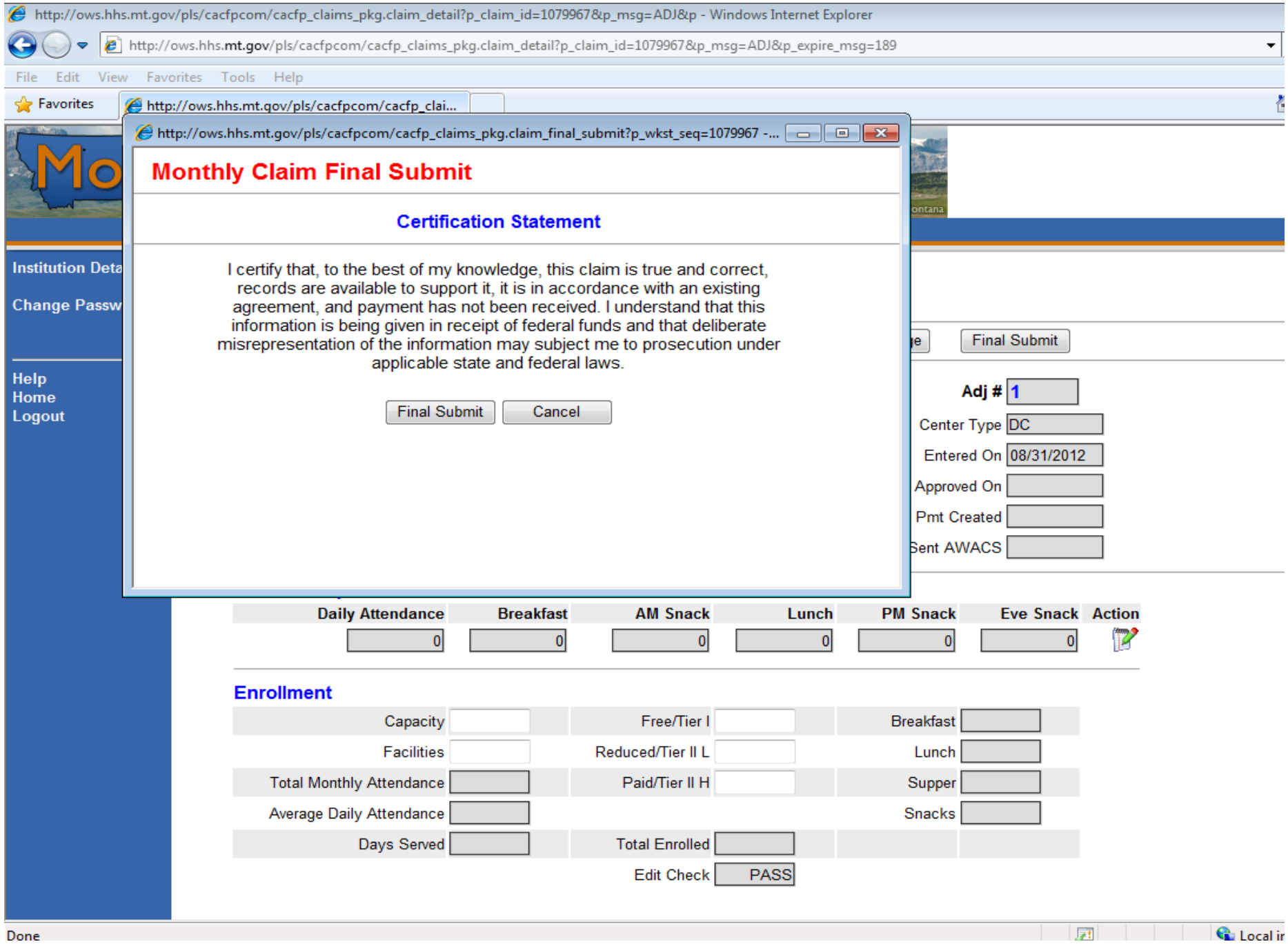
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Monthly Claim Final Submit
Certification Statement
I certify that, to the best of my knowledge, this claim is true and correct, records are available to support it, it is in accordance with an existing agreement, and payment has not been received. I understand that this information is being given in receipt of federal funds and that deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.
Final Submit
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Breakfast
Lunch
Supper
Snacks
Done

CACFP Meal Benefit Income Eligibility Forms

Meal Benefit Forms are not required for Head Start or Afterschool Programs operating the CACFP

For-Profit Centers

Each month: At least 25% of enrolled children or licensed capacity, whichever is less, must be classified as Free or Reduced, to claim meals for that month. If less than 25%, then that month's claim is not payable.

The Meal Benefit Income Eligibility form is the basis for the financial benefit you receive

Important things to remember when completing the forms

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care) **13**

Institution or Facility Name:		
Part 1. Name of Child(ren) Enrolled:		
Full names of all household members	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM.	CHECK IF NO INCOME
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household received [SNAP], [FDPIR], [TANF cash assistance] or [Medicaid], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**
NAME:_____ CASE NUMBER: _____

Part 3. If any child you are applying for is homeless, migrant, or a runaway, call the State agency for instructions.

Part 4. Total Household Gross Income—You must tell us how much and how often

	B. Gross income and how often it was received

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

13

List all enrolled children's names here

List all family member's names here

Institution or Facility Name:

Part 1. Name of Child(ren) Enrolled:

Full names of all household members	CHECK IF FOSTER CHILD (FOR WHOM RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO SIGN THIS FORM	CHECK IF NO INCOME
	☐	☐
	☐	☐

Part 2. Benefits: If any member of your household received [SNAP], [FDPIR], [TANF cash assistance] or [Medicaid], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ CASE NUMBER: _____

Part 3. If any child you are applying for is homeless, migrant, or a runaway, call the State agency for instructions.

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received** 1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All other income
(Example) *Jane Smith*	$200/weekly_____	$150/twice a month_	$100/monthly_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Montana CACFP

CACFP MEAL BENEFIT INCOME ELIGIBILITY FORM (Child Care)

13

Institution or Facility Name:

Part 1. Name of Child(ren) Enrolled:

	CHECK IF A FOSTER CHILD (THE LEGAL RESPONSIBILITY OF A WELFARE AGENCY OR COURT) * IF ALL CHILDREN LISTED BELOW ARE FOSTER CHILDREN, SKIP TO PART 5 TO	
Full names of all h		CHECK IF NO INCOME
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	☐	☐
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	☐	☐

Important! Must provide either income information OR case number (includes Medicaid)

Part 2. Benefits: If any member of your household received [SNAP], [FDPIR], [TANF cash assistance] or [Medicaid], provide the name and case number for the person who receives benefits. **If no one receives these benefits, skip to part 3.**

NAME:_____ CASE NUMBER:_____

Part 3. If any child you are applying for is homeless, migrant, or a runaway, call the State agency for instructions.

Part 4. Total Household Gross Income—You must tell us how much and how often

	B. Gross income and how often it was received			
A. Name	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All other income
			$100/monthly	$_____/_____
			$_____/_____	$_____/_____

If a case number is provided, then no income information is required in Part 4

NAME:_____ CASE NUMBER: _____

Part 3. If any child you are applying for is homeless, migrant, or a runaway, call the State agency for instructions.

Part 4. Total Household Gross Income—You must tell us how much and how often

A. Name (List **only** household members with income)	**B. Gross income and how often it was received**			
	1. Earnings from work before deductions	2. Welfare, child support, alimony	3. Pensions, retirement, Social Security, SSI, VA benefits	4. All other income
(Example) *Jane Smith*	$200/weekly	$150/twice a month	$100/monthly	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____
	$_____/_____	$_____/_____	$_____/_____	$_____/_____

Part 5. Signature and Last Four Digits of Social Security Number (Adult must sign)

An adult household member must sign this form. **If Part 3 is completed, the adult signing the form must also list the last four digits of his or her Social Security Number or mark the "I do not have a Social Security Number" box.** (See Statement on the back of this page.)

Part 5 MUST be completed!

I certify that all information on this form is true *nd that the center or day care home will get Federal funds based on the informatio* *may verify the information. I understand that if I purposely give false inform* *lose the meal benefits, and I may be prosecuted.*

Sign here: _____ Print name: _____

Date: _____

Address: _____ Phone Number: _____

City:_____ State: _____ Zip Code: _____

Last four digits of Social Security Number: X X X - X X - _ _ _ _ ❑ I do not have a Social Security Number

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

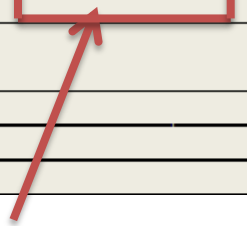
Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date:_____



Denied = Paid

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date:_____

Tier 1 and Tier II – Applies to child care homes

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

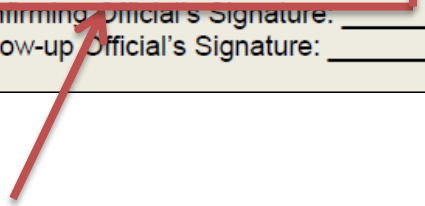
Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date:_____



Determining Official's Signature – REQUIRED, authorized representative from your center, not complete without it

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____

Not required:

- Confirming Official's Signature – CACFP
- Follow-Up Official's Signature – Auditor

Part 6. Participant's ethnic and racial identities (optional)

Mark one ethnic identity:	Mark one or more racial identities:	
❑ Hispanic or Latino	❑ Asian	❑ American Indian or Alaska Native
❑ Not Hispanic or Latino	❑ White	❑ Native Hawaiian or Other Pacific Islander
	❑ Black or African American	

Part 7. Decline to provide information

I choose not to provide information about my household size and income.

_____ _____

Signature of Adult Household Member Date

Don't fill out this part. This is for official use only.

Annual Income Conversion: Weekly x 52, Every 2 Weeks x 26, Twice A Month x 24, Monthly x 12

Total Income: _____ Per: ❑ Week, ❑ Every 2 Weeks, ❑ Twice A Month, ❑ Month, ❑ Year Household size: _____

Categorical Eligibility: ___ Date Withdrawn: _____ Eligibility: Free___ Reduced___ Denied___ Tier I_____ Tier II____

Reason: _____

Determining Official's Signature: _____ Date: _____

Confirming Official's Signature: _____ Date: _____

Follow-up Official's Signature: _____ Date: _____

The participant in the day care facility may qualify for free or reduced price meals if your household income falls within the limits on this chart.

	Tier I	
Household size	Yearly (Free)	Yearly (Reduced)
1	<$14,521	<$20,665
2	<$19	
3	<$24	
4	<$29	
5	<$35	
6	<$40,261	<$57,295
7	<$45,409	<$64,621
8	<$50,557	<$71,947
Each additional person:	<$5,148	<$7,326

Verify your determination matches income guidelines

Forms are valid for 12 months only

- Valid from July 1st to June 30th
- Must complete a new form every year

Meal Start Times

The USDA:

- Does not address start times for CACFP meals
- Leaves this up to States and child care institutions

The CACFP Follows Child Care Licensing Rules

Child Care Licensing rules for child care centers states the following:

At a minimum:

- Breakfast at 9:00 AM or before
- Snacks at mid-morning and mid-afternoon
- Lunch
- Supper if a child is being cared for in the center at the normal time for this meal and has not otherwise received it

[37.95.215, page 51, Rev. Sept 2006]

Start times for meals

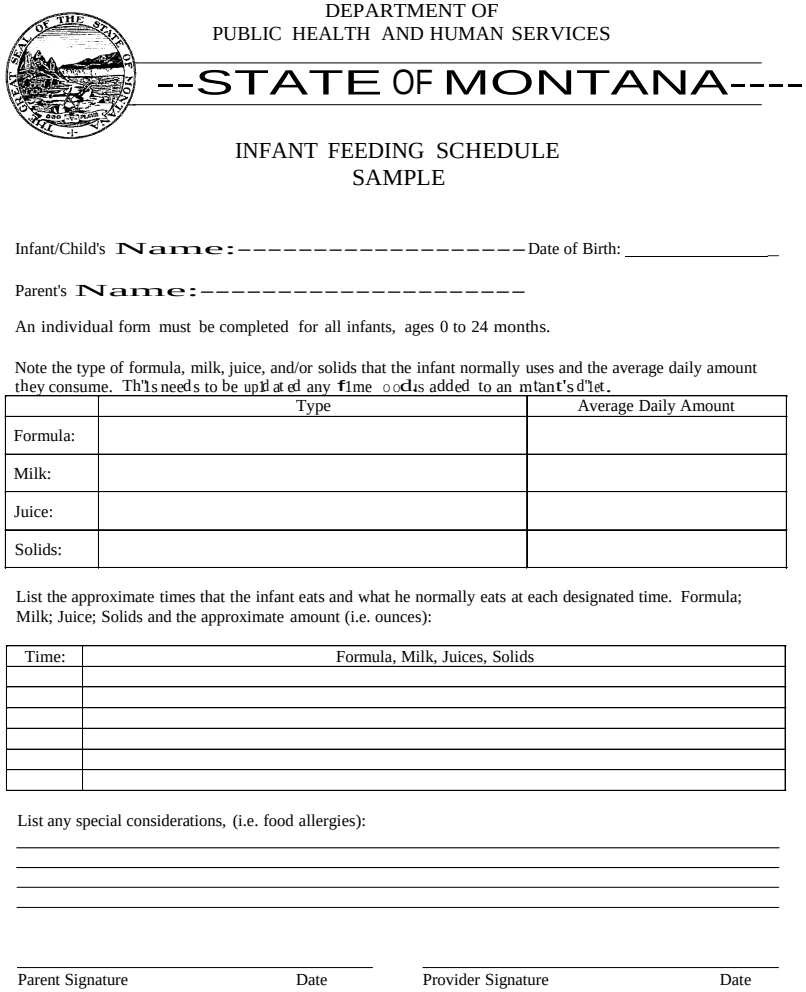
- Required information in CACFP applications
- Can be revised by you in your application and must be approved by the State agency
- Must begin on time

Duration of meals

There is no requirement for
the duration of meals
by Child Care Licensing
or by the CACFP

Infants ages 0-24 months

- Infant Feeding Schedules are required for all infants
- Centers must follow the schedule provided by parents
- Infant feedings claimed as CACFP meals must be fed to the infant at or near to the normal start time of those meals



DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

--STATE OF MONTANA----

INFANT FEEDING SCHEDULE
SAMPLE

Infant/Child's Name:---------- Date of Birth: _____

Parent's Name:----------

An individual form must be completed for all infants, ages 0 to 24 months.

Note the type of formula, milk, juice, and/or solids that the infant normally uses and the average daily amount they consume. This needs to be updated any time foods added to an infant's diet.

	Type	Average Daily Amount
Formula:		
Milk:		
Juice:		
Solids:		

List the approximate times that the infant eats and what he normally eats at each designated time. Formula; Milk; Juice; Solids and the approximate amount (i.e. ounces):

Time:	Formula, Milk, Juices, Solids

List any special considerations, (i.e. food allergies):

_____
_____
_____
_____

_____ _____
Parent Signature Date Provider Signature Date

Afterschool Program Exception

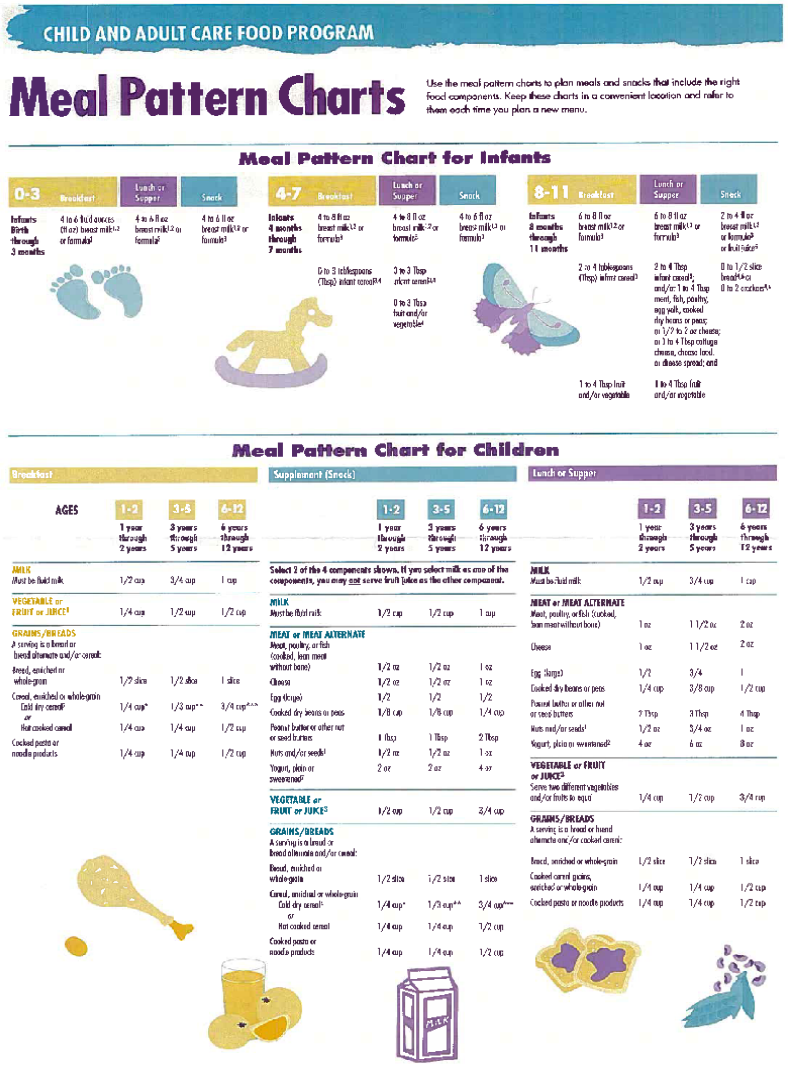
- Provides up to 1 meal and 1 snack
- The order of and start time of those meals is determined by the institution and approved by the State agency
- The program goal is to serve nutritionally adequate meals and prevent childhood hunger

Food Production Records

Food Production records save time and money.

Plan ahead so the correct amount of food is purchased and prepared.

Food Production Records help to ensure meals and snacks meet the CACFP meal pattern.



CHILD AND ADULT CARE FOOD PROGRAM

Meal Pattern Charts

Use the meal pattern charts to plan meals and snacks that include the right food components. Keep these charts in a convenient location and refer to them each time you plan a new menu.

Meal Pattern Chart for Infants

	0-3 Breakfast	0-3 Lunch or Supper	0-3 Snack	4-7 Breakfast	4-7 Lunch or Supper	4-7 Snack	8-11 Breakfast	8-11 Lunch or Supper	8-11 Snack
Infants	Birth through 3 months	4 to 6 fluid ounces (breast milk[1,2] or formula[3])	4 to 6 fl oz breast milk[1,2] or formula[3]	4 to 6 fl oz breast milk[1,2] or formula[3]	4 to 8 fl oz breast milk[1,2] or formula[3]	2 to 4 fl oz breast milk[1,2] or formula[3]	4 to 8 fl oz breast milk[1,2] or formula[3]	6 to 8 fl oz breast milk[1,2] or formula[3]	2 to 4 fl oz breast milk[1,2] or formula[3] or fruit juice[4]
				0 to 3 tablespoons (Tbsp) infant cereal[3,4]	2 to 3 Tbsp infant cereal[3,4]		2 to 4 tablespoons (Tbsp) infant cereal[3]	2 to 4 Tbsp infant cereal[3]; and/or 1 to 4 Tbsp meat, fish, poultry, egg yolk, cooked dry beans or peas; or 1/2 to 2 oz cheese; or 1 to 4 Tbsp cottage cheese, cheese food, or cheese spread; and	0 to 1/2 slice bread[4,5] or 0 to 2 crackers[4,5]
					0 to 2 Tbsp fruit and/or vegetable[5]			1 to 4 Tbsp fruit and/or vegetable	0 to 4 Tbsp fruit and/or vegetable

Meal Pattern Chart for Children

Breakfast

AGES	1-2 (1 year through 2 years)	3-5 (3 years through 5 years)	6-12 (6 years through 12 years)
MILK Must be fluid milk	1/2 cup	3/4 cup	1 cup
VEGETABLE or FRUIT or JUICE[1]	1/4 cup	1/2 cup	1/2 cup
GRAINS/BREADS A serving is a bread or bread alternate and/or cereal:			
Bread, enriched or whole-grain	1/2 slice	1/2 slice	1 slice
Cereal, enriched or whole-grain: Cold dry cereal[2] or	1/4 cup*	1/3 cup**	3/4 cup***
Hot cooked cereal	1/4 cup	1/4 cup	1/2 cup
Cooked pasta or noodle products	1/4 cup	1/4 cup	1/2 cup

Supplement (Snack)

Select 2 of the 4 components shown. If you select milk as one of the components, you may not serve fruit juice as the other component.

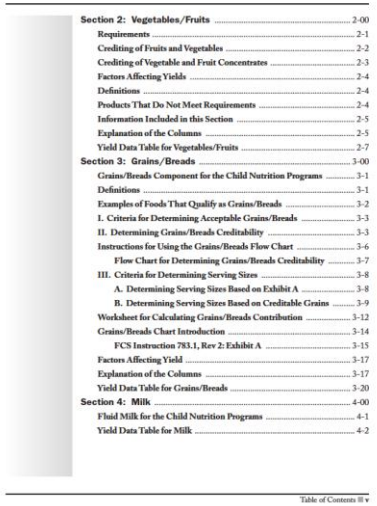
	1-2 (1 year through 2 years)	3-5 (3 years through 5 years)	6-12 (6 years through 12 years)
MILK Must be fluid milk	1/2 cup	1/2 cup	1 cup
MEAT or MEAT ALTERNATE Meat, poultry, or fish (cooked, lean meat without bone)	1/2 oz	1/2 oz	1 oz
Cheese	1/2 oz	1/2 oz	1 oz
Egg (large)	1/2	1/2	1/2
Cooked dry beans or peas	1/8 cup	1/8 cup	1/4 cup
Peanut butter or other nut or seed butters	1 Tbsp	1 Tbsp	2 Tbsp
Nuts and/or seeds[3]	1/2 oz	1/2 oz	1 oz
Yogurt, plain or sweetened[2]	2 oz	2 oz	4 oz
VEGETABLE or FRUIT or JUICE[1]	1/2 cup	1/2 cup	3/4 cup
GRAINS/BREADS A serving is a bread or bread alternate and/or cereal:			
Bread, enriched or whole-grain	1/2 slice	1/2 slice	1 slice
Cereal, enriched or whole-grain: Cold dry cereal[2] or	1/4 cup*	1/3 cup**	3/4 cup***
Hot cooked cereal	1/4 cup	1/4 cup	1/2 cup
Cooked pasta or noodle products	1/4 cup	1/4 cup	1/2 cup

Lunch or Supper

	1-2 (1 year through 2 years)	3-5 (3 years through 5 years)	6-12 (6 years through 12 years)
MILK Must be fluid milk	1/2 cup	3/4 cup	1 cup
MEAT or MEAT ALTERNATE Meat, poultry, or fish (cooked, lean meat without bone)	1 oz	1 1/2 oz	2 oz
Cheese	1 oz	1 1/2 oz	2 oz
Egg (large)	1/2	3/4	1
Cooked dry beans or peas	1/4 cup	3/8 cup	1/2 cup
Peanut butter or other nut or seed butters	2 Tbsp	3 Tbsp	4 Tbsp
Nuts and/or seeds[3]	1/2 oz	3/4 oz	1 oz
Yogurt, plain or sweetened[2]	4 oz	6 oz	8 oz
VEGETABLE or FRUIT or JUICE[1] Serve two different vegetables and/or fruits to equal	1/4 cup	1/2 cup	3/4 cup
GRAINS/BREADS A serving is a bread or bread alternate and/or cooked cereal:			
Bread, enriched or whole-grain	1/2 slice	1/2 slice	1 slice
Cooked cereal grains, enriched or whole-grain	1/4 cup	1/4 cup	1/2 cup
Cooked pasta or noodle products	1/4 cup	1/4 cup	1/2 cup

Helpful Tools

- **A calculator**
- **USDA Food Buying Guide Online Calculator**



- **1 cup Food Examples**
- **Food Buying Guide for Child Nutrition Programs**

Found on our website under:

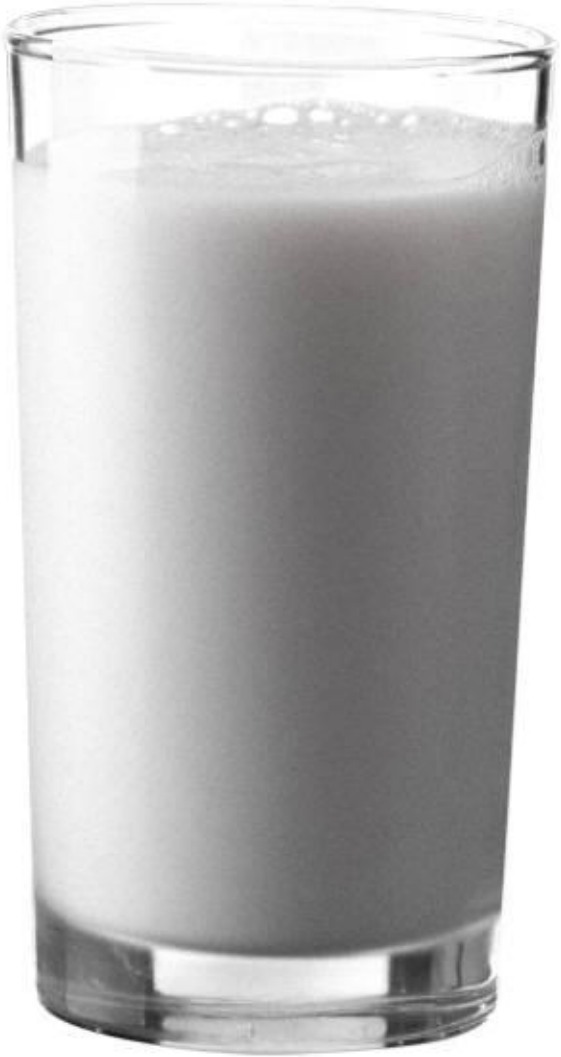
Resources > Materials > Food Production

1. CACFP Food Production Record

2. Name of Child Care Business, City, State: CACFP Kids

3. Name of the Person Responsible: Chef Charlie

4. Date 3/5/12	5. Menu	6. Foods Used	7. Purchase Unit	8. Serving Size	9. # of Servings to Prepare	10. Amount of Food to Prepare
Breakfast Time: 8:00 Must include: 1 Fluid Milk 1 Fruit / Veg 1 Bread / Grain	Pancakes	Brand name pancake mix	1 lb. makes 16 3oz. pancakes	2 pancakes or 6oz.	25	25x2=50 cakes 50/16=3.13 or 3.5 lbs. mix
	Applesauce	Applesauce	1 #10 can = 108 oz	4 oz	25	25 x 4 = 100 oz 108/100=1.08 1#10 and 1 16oz can
	milk	1 gal. = 128 oz.	gal	6 oz	25	25 x 6oz = 150oz 150/128=1.17 or 2 gallons
AM Snack Time: 10:00 Must include: 2 foods from the 4 food groups	cheese	cheddar	pound	1/2 oz.	25	25x1/2oz.=12.5 oz. or 1lb
	crackers	Brand name whole grain	Box/48oz.	1 G/B serving = 8 saltines; must weigh at least 0.9 oz	25	25x.9oz.=22.5 oz. or 1.4lbs or 1 box
	milk	1 gal. = 128 oz.	gal	6 oz.	25	2 gal.
Lunch Time: 12:00 Must include: 1 Fluid Milk 1 Meat / Beans 2 Fruit / Veg 1 Bread / Grain	Taco Salad	Ground Beef Lettuce - 1lb.=22.2 1/4 cup servings	pound pound	1.5 oz. 1/2 cup	25 25	25 x 1.5oz.=37.5 37.50/16=2.34 or 3 lbs. lett.=25x1/2c. =12.5c.x4=50 or 3 lbs.
	Corn	Brand name canned	1 # 10 can = 108 oz.	4 oz	25	25 x 4 = 100 oz. 1 #10 can
	Pears	Brand name canned	1 #10 can = 108 oz	4 oz	25	25x4 = 100 oz. 1 #10 can
	Milk	1 gal = 128 oz.	gal.	6 oz	25	25 x 6=150/128



Milk:

Are you serving enough?

What's the big deal anyway?

Gauges your overall food service . . .

Highly nutritious

Are their glasses full?

How much is enough?

- Ages 1 – 2 serve 4 oz
- Ages 3 – 5 serve 6 oz
- Ages 6 – 12 serve 8 oz

Size matters!

Make sure the cups you are using are large enough for at least one serving of milk


Clear cups are best!

Pour it for them!

- Purchase at least weekly
- Ensure enough refrigerator space and FILL IT!
- Buy more than required
- Buy from a vendor

Never let the well go dry!

Calculate it!

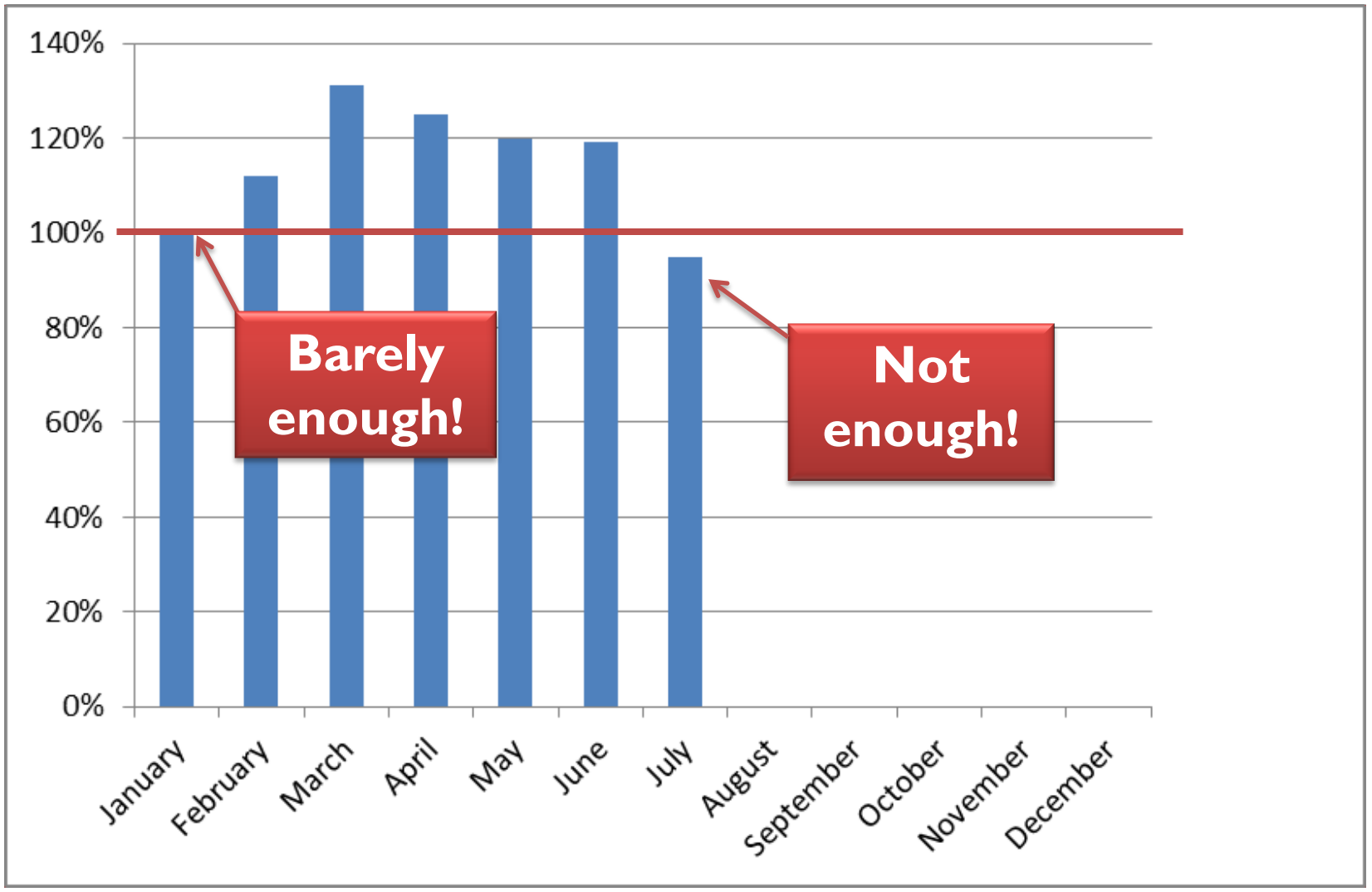
- Use worksheets
- Calculate in advance

# of Children	Ages 1-2 4 oz.	Ages 3-5 6 oz.	Ages 6-12 8 oz.
5	.16	.23	.31
10	.31	.47	.63
15	.47	.70	.94
20	.63	.94	1.25
25	.78	1.17	1.56
30	.94	1.41	1.88
35	1.09	1.64	2.19
40	1.25	1.88	2.50
45	1.41	2.11	2.81
50	1.56	2.34	3.13
55	1.72	2.58	3.44
60	1.88	2.81	3.75
65	2.03	3.05	4.06
70	2.19	3.28	4.38
75	2.34	3.52	4.69
80	2.50	3.75	5.00

Minimum Gallons of Milk Needed Per Meal

(Round up to next whole gallon)

ALWAYS purchase 100% or more



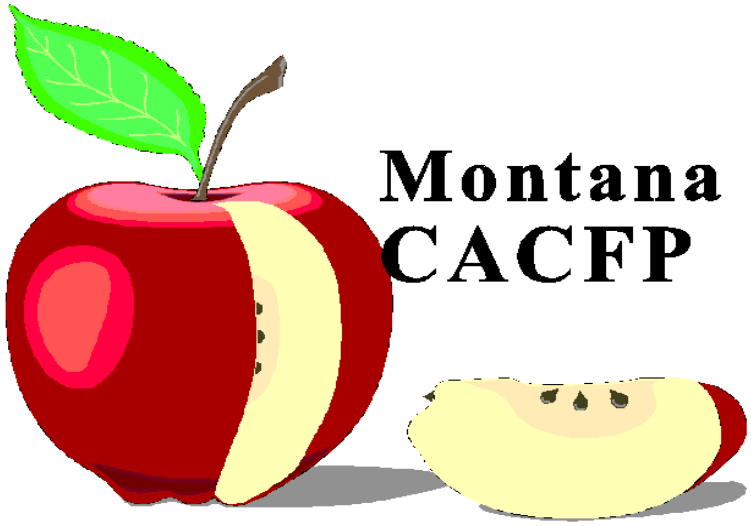
Increase purchases to greater than 100%

How else can I use milk?

- Serve as much as they want at mealtime
- Serve at snack time
- Use it in recipes

Better to purchase too much than to not purchase enough

CACFP Recordkeeping



Organize Required Documents and Information

A - H

Application and Contract
Audits, Annual audit questionnaires
Attendance, child's (sign in and out)
Civil Rights and CACFP Training (agenda, time, date, attendance)
Claims, pink worksheets, log sheets
Handbook, parent

I - P

IEG's, IEF's & Monthly Attendance – Free, Reduced, Paid – Confidential
Infant Feeding Schedules (posted)
Menus and Food Production Records
Payroll records (cook, director – CACFP admin. Only)
Policies

R - T

Receipts, Food and Milk – monthly
Recipes, current
Reviews and visits
Sanitarian's reports
Special Dietary Needs forms – Confidential
Training, employee, Staff

Center

Application and Contract
Audits, Annual audit questionnaires
Civil Rights and CACFP Training (agenda, time, date, attendance)
Claims, pink worksheets, log sheets
Handbook, parent
Payroll records (cook, director – CACFP admin. Only)
Policies
Reviews and visits

Children

Attendance, child's (sign in and out)
IEG's, IEF's & Monthly Attendance – Free, Reduced, Paid - **Confidential**
Infant Feeding Schedules (posted)
Special Dietary Needs forms - **Confidential**

Food

Menus and Food Production Records
Receipts, Food and Milk – monthly
Recipes, current
Sanitarian's reports

To Be Posted

1. License, if applicable

2. Menu for current and following week

3. “Justice For All”

4. Federal Relay Poster

5. WIC – income guidelines

6. Hand washing posters

“Justice For All”

“In accordance with Federal law and U.S. Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability.

To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue SW, Washington, D.C. 20250-9410, or call (800) 795-3272 (voice) or (202)720-6382 (TTY).

USDA is an equal opportunity provider and employer.”

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Reminders to Directors:

- CACFP records must be maintained on site.
- Always have a person on staff appointed by you, present and prepared to act in your absence and who has knowledge of and access to all of your CACFP records.